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AETNA LIFE INSURANCE COMPANY, THE PARSONS BRINCKERHOFF GROUP ADMINISTRATION, INC. SHORT TERM DISABILITY PLAN AND THE PARSONS BRINCKERHOFF GROUP ADMINISTRATION, INC. LONG TERM DISABILITY PLAN

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

ELIZABETH FOWLER,

Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY; THE PARSONS BRINCKERHOFF GROUP ADMINISTRATION, INC. SHORT TERM DISABILITY PLAN; THE PARSONS BRINCKERHOFF GROUP ADMINISTRATION, INC. LONG TERM DISABILITY PLAN; and DOES 1 through 20, INCLUSIVE,

Defendants.

CASE NO. 3:08-cv-03463 (MEJ)

**DECLARATION OF GAIL MINOSKI IN SUPPORT OF THE DEFENDANTS' MOTION TO DISMISS [FED. R. CIV. P. 12(b)(6)] AND MOTION TO STRIKE [FED. R. CIV. P. 12(f)]**

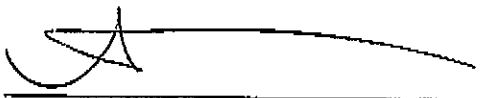
ORAL ARGUMENT REQUESTED

I, Gail Minoski, declare as follows:

1. I am a manager with Aetna Life Insurance Company ("Aetna"). I submit this declaration in support of Defendants' Motion to Dismiss plaintiff Elizabeth Fowler's Second Cause of Action and request for jury trial contained in her first amended complaint, and motion to strike Fowler's claims for emotional distress and an injunction in the above referenced action. I have personal knowledge of the matters contained herein, except as those based on information and belief. If called as a witness in this action, I could and would competently testify thereto.

2. Attached hereto as **Exhibit A** is a true and correct copy of The Parsons Brinckerhoff Group Administration, Inc. Temporary Disability Income Plan, and The Parsons Brinckerhoff Group Administration, Inc. Long Term Disability Plan (Aetna Life Insurance Company Group Policy No. 101979), issued to The Parsons Brinckerhoff Group Administration, Inc., effective January 1, 2005.

3. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct and that this declaration was executed in Middletown, CT, on July 25, 2008.



Gail Minoski, Manager

# EXHIBIT A

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(Defines the Terms Shown in Bold Type in the Text of This Document.)

Note: The codes appearing on the left side of certain blocks of text are required by the State of New York.

# Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.

Ronald A Williams

President

Group Policy: GP-101979
Cert. Base: 2
Issue Date: March 29, 2005
Effective Date: January 1, 2005

*0020*

# Temporary Disability Income Coverage

This Plan will pay a Weekly Benefit, as described below, for a period of disability caused by a non-occupational disease or **injury**. There is a Elimination Period. (This is the length of time during a period of disability that must pass before benefits start.)

A "non-occupational disease or **injury**" is defined as a disease or **injury** that does not:

- arise out of or in the course of any activity in connection with:

  employment; or

  self-employment;

  whether or not on a full time basis; and
- result, in any way, from a disease or **injury**, which arises out of such activity.

If proof is furnished to Aetna that a person under the workers' compensation law (or other like law):

- has made claim under such law in connection with a distinct disease or **injury**; and
- no benefit, award, settlement or redemption has been or will be made under that law for such disease or **injury**;

that disease or **injury** will be considered non-occupational.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

## Definition of Disability

You will be deemed to be disabled if you are not able, solely because of disease or **injury**, to perform the **material duties** of your **own occupation.**

You will not be deemed to be performing the **material duties** of your **own occupation** if:

- you are performing some of the **material duties** of your **own occupation**; and
- solely due to disease or **injury**, your income is 80% or less of your **predisability earnings.**

If your **own occupation** requires a professional or occupational license or certification of any kind, you will not be deemed to be disabled solely because of loss of license or certification.

*11101, 11528*

## Benefits Payable

The benefit is an amount based on your **predisability earnings**, multiplied by the scheduled benefit percentage. Other income benefits, as defined later, will reduce the benefit actually payable.

If no other income benefits are payable for a given week, the benefit payable under this Plan for that week will be the lesser of:

the Weekly Benefit; and
the Maximum Weekly Benefit.

If other income benefits are payable for a given week, the benefit payable under this Plan for that week will be the lesser of:

the Weekly Benefit; and
the Maximum Weekly Benefit;

*11101*

minus all other income benefits.

## When Benefits Are Payable

Weekly benefits will be payable if a disability:

- is caused by a non-occupational disease or **injury** as defined above; and
- starts while you are covered; and
- continues during and past the Elimination Period.

*11102*

The benefits are payable, after the Elimination Period ends, for as long as you continue to be disabled, up to the Maximum Weekly Benefit Period for any one period of disability.

## Period of Disability

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under this Plan. You must be under the regular care of a **physician**. (You will not be deemed to be under the regular care of a **physician** more than 31 days before the date he or she has seen and treated you in person for the disease or **injury** that caused the disability).

A period of disability ends on the first to occur of:

- The date Aetna finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date you cease to be under the regular care of a **physician**.
- The date you refuse to be examined by, or cooperate with, an independent **physician** or a licensed or certified health care practitioner, as requested.
- The date an independent medical exam report or functional capacity evaluation fails to confirm your disability.
- The date you reach the end of your Maximum Weekly Benefit Period.
- The date you are not undergoing effective treatment for alcoholism or drug abuse, if your disability is caused to any extent by alcoholism or drug abuse. Effective treatment for alcoholism and drug abuse means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

  has a follow-up therapy program directed by a **physician** on at least a monthly basis; or

includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

Detoxification. This means solely treating the aftereffects of a specific episode of alcoholism or drug abuse.

Maintenance care. This means primarily providing an environment free of alcohol or drugs.

- The date you refuse to cooperate with or accept:

  changes made to a work site or job process to suit your identified medical limitations; or

  adaptive equipment or devices designed to suit your identified medical limitations;

  which would enable you to perform your **own occupation** and provided that a **physician** agrees that such changes or adaptive equipment suit your medical limitations.
- The date you refuse to receive treatment recommended by your attending **physician** that in Aetna's opinion would: cure; correct; or limit your disability.
- The date your condition would permit you to work or increase the number of hours you work, or the number or type of duties you perform in your **own occupation**, but you refuse to do so.
- The date you become eligible for benefits under any other disability benefits plan of the same type carried or sponsored by your Employer, if such date occurs after the date the group contract terminates.
- The date of your death.
- The day after Aetna determines you are able to participate in **An Approved Rehabilitation Program** and you refuse to do so.

*11102; 11205-2*

## How Separate Periods of Disability Are Treated

Once a period of disability has ended, any new period of disability will be treated separately. However, if two or more periods of disability are:

- due to the same or related causes; and
- separated by less than 15 days in a row;

they will be deemed to be one period of disability. Only one Elimination Period will apply. The first period will not be included if it began while you were not covered.

*11103*

**Other Income Benefits**

They are:

*7537*
*7537, 7537-2*

- 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.

- Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:

  Unemployment compensation benefits.

  Temporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.

  Automobile no-fault wage replacement benefits to the extent required by law.

  Statutory disability benefits.

  Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.

*7537, 7537-2*

  Veterans' benefits.

*7537, 7537-2*

- Statutory disability benefits.

- Disability or unemployment benefits under any plan or arrangement of coverage (other than group life insurance if they would reduce the amount of group life insurance):

  as a result of employment by or association with the Employer; or

  as a result of membership in or association with any group, association, union or other organization.

*7537, 7537-2*

  This includes both, plans that are insured and those that are not.

- Unreduced retirement benefits for which you are or may become eligible under your Employer's group pension plan at the later of:

  age 62, and

  the Plan's Normal Retirement Age,

*7608*

  but only to the extent that such benefits were paid for by your Employer.

- Voluntarily elected retirement benefits received under a group pension plan provided by your Employer, but only to the extent that such benefits were paid for by your Employer.

*7607*

- Disability payments which result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.

*7537*

*7537*

- Disability benefits under any group mortgage or group credit disability plan.

*7537*

Other income benefits include those, due to your disability or retirement, which are payable to: you; your spouse; your children; your dependents.

## Effect of Increases In Other Income Benefits

Increases in the level of other income benefits due to the following will be considered "other income benefits":

- a change in the number of your family members;
- a recomputation or recalculation to correct or adjust your benefit level as first established for the period of disability; or
- a change in the severity of your disability.

There may be cost of living increases in the level of other income benefits received from a governmental source during a period of disability. These increases will not be deemed to be "other income benefits."

*7539*

There may be cost of living or general increases in the level of other income benefits from a non-governmental source during a period of disability. These increases will not be considered other income benefits to the extent they are based on the annual average increase in the **Consumer Price Index**.

## Other Income Benefits Which Do Not Reduce Monthly Benefits

The amount of any retirement or disability benefits you were receiving from the following sources before the date a period of disability started will not reduce your monthly benefits:

- military and other government service pensions;
- retirement benefits from a prior employer; and
- veterans' benefits for service related disabilities; and
- individual disability income policies; and
- Federal Social Security Act.

Also, the amount of any income or other benefits you receive from the following sources will not reduce your monthly benefits:

- profit sharing plans;
- thrift plans;
- 401(k) plans;
- Keogh plans;
- employee stock option plans;
- tax sheltered annuity plans;
- severance pay;
- individual disability income policies;
- individual retirement accounts (IRAs); or
- a retirement plan sponsored by your employer, to the extent that payments are due to any amount which has been rolled over or transferred from a prior, unrelated employer's retirement plan.

*7539*

## How Aetna Determines Other Income Benefits

### Lump Sum and Periodic Payments From Any Other Income Benefit

Any lump sum or periodic other income (described elsewhere in this certificate) that you receive will be prorated on a monthly basis over the period of time for which the payment was made. If a period of time is not indicated, Aetna will prorate the payments over your expected lifetime, as determined by Aetna.

That part of the lump sum or periodic payment that is for disability will be counted, if it is not specifically apportioned or identified as such.

*7538, 11206*

Any of these "Other Income Payments" that date back to a prior date during a period of disability may be allocated on a retroactive basis.

## Estimated Other Income Payments

The amount of other income benefits for which you appear to be eligible may be estimated, unless you have signed and returned a reimbursement agreement to Aetna. This agreement contains your promise to repay Aetna for any overpayment of benefits made to you.

If other income benefits are estimated, your weekly benefit will be adjusted when Aetna receives proof:

- of the exact amount awarded; or
- that benefits have been denied after review at the highest administrative level.

*7538*

Aetna will pay you if any underpayment in your benefit results. You will have to repay Aetna if any overpayment of benefits has resulted. When Aetna has to take legal action against you to recover any overpayment, you will also have to pay Aetna's reasonable attorney's fees and court costs, if Aetna prevails.

## Required Proof of Income

Aetna has the right to require proof that:

- you, your spouse, child, or dependent has made application for all other income benefits which you or they are, or may be, eligible to receive relative to your disability and has made a timely appeal of any denial through the highest Administrative level; timely appeal means making such an appeal as required, but in no case later than 60 days from the latest denial;
- the person has furnished proof needed to obtain other income benefits, which includes, but is not limited to, Workers' Compensation Benefits;
- the person has not waived any other income benefits without Aetna's written consent; and
- the person has sent copies of the documents to Aetna showing the effective dates and the amounts of other income benefits.

In addition to the above, for purposes of Federal Social Security, when a timely application for benefits has been made and denied, a request for reconsideration must be made within 60 days after the denial, unless Aetna states, in writing, that it does not require you to do so. Also, if the reconsideration is denied, an application for a hearing before an Administrative Law Judge must be made within 60 days of that denial unless Aetna relieves you of that obligation.

Aetna also requires proof:

- of income you receive from any occupation for compensation or profit; and
- if your income from any such occupation is 80% or less of your **adjusted predisability earnings**, proof that you are unable, due to disease or **injury**, to earn more than 80% of your **adjusted predisability earnings**.

You do not have to apply for:

- retirement benefits paid only on a reduced basis; or

- disability benefits under group life insurance if they would reduce the amount of group life insurance;

but, if you do apply for and receive these benefits, they will be deemed to be other income benefits for which proof is required.

If you do not furnish proof of other income benefits, Aetna reserves the right to suspend or adjust benefits by the estimated amount of such other income benefits.

*7686; 7543-1*

## Rehabilitation

Aetna retains the right to evaluate you for participation in **An Approved Rehabilitation Program**.

If, in Aetna's judgment, you are able to participate, Aetna may, in its sole discretion require you to participate in **An Approved Rehabilitation Program**.

This Plan will pay for all services and supplies, approved in advance by Aetna, needed in connection with such participation; except for those for which you can otherwise receive reimbursement from any third party payor, including any governmental benefits to which you may be entitled.

*7687*

## Exclusions

Temporary Disability Income Coverage does not cover any disability that:

- is due to intentionally self-inflicted injury (while sane or insane).
- results from your commission of, or attempt to commit, a felony.
- results from driving an automobile while intoxicated. ("Intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred.)
- is due to war or any act of war (declared or not declared).
- is due to insurrection, rebellion, or taking part in a riot or civil commotion.
- is not a non-occupational disease or **injury** (as defined above); except for sole-proprietors or partners who cannot be covered by workers' compensation law.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- the person will not be deemed to be disabled; and
- no benefits will be payable.

*7688; 7541-1*

# Effect Of Benefits Under Other Plans

*5030*

## Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another

*6051*

group contract or any benefit section of this Plan.

A person's coverage under the Temporary Disability Income Coverage section of this Plan replaces and supersedes any prior like coverage. It will be in exchange for all privileges and benefits provided under such prior coverage except coverage will not be available as to a particular period of disability for which a benefit is available, or would

*7691*

be available, under the prior coverage in the absence of coverage under this Plan.

# General Information About Your Coverage

## Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan., This date will be the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or **injury**, your employment may be continued until stopped by your Employer, but not beyond 12 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment will be deemed to cease on your last full day of active work before the start of the lay-off or leave of absence.

In figuring when employment will stop for the purpose of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

*6080*

If you cease active work, ask your Employer if any coverage can be continued.

## Temporary Disability Income Benefits After Termination

*6080*

If your Temporary Disability Income coverage terminates during a period of disability which began while you had coverage, any Temporary Disability Income benefits will be available as long as your period of disability continues.

## Examinations and Evaluations

*7543*

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while that claim is pending or payable. This will be done at Aetna's expense.

## Legal Action

*6470*

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

## Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

*6470*

## Reinstatement of Coverage

If your coverage terminates, you may again become covered in accordance with the terms of this Plan; except that if:

you return to active work within 24 months of the date coverage terminated;

any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

*7690*

## Assignments

*6430*

Coverage may be assigned only with the written consent of Aetna.

## Recovery of Overpayments

If payments are made in amounts greater than the benefits that you are entitled to receive, Aetna has the right to do any one or all of the following:

- to require you to return the overpayment on request;
- to stop payment of benefits until the overpayment is recovered;
- to take any legal action needed to recover the overpayment; and
- to place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

If the overpayment:

- occurs as a result of your receipt of other income benefits for the same period for which you have received a benefit under this Plan; and
- to obtain such other income benefits, advocate or legal fees were incurred;

Aetna will exclude from the amount to be recovered, such advocate or legal fees; provided you return the overpayment to Aetna within 30 days of Aetna's written request for the overpayment. If you do not return the overpayment to Aetna within such 30 days, such fees will not be excluded; you will remain liable for repayment of the total overpaid amount.

An example of "other income" referred to in the preceding paragraph is Workers' compensation.

*7543*

## Reporting of Claims

A claim must be submitted by following the procedure chosen by your Employer. If the procedure requires that claim forms be submitted, they may be obtained at your place of employment or from Aetna. It must give proof of the nature and extent of the loss.

If you must be out of work because you are disabled, a claim for a Temporary Disability Income Benefit should be made right away. Do not wait until you go back to work. This may delay payment of benefits. The deadline for filing a claim for these benefits is 31 days after your benefits are first payable.

*11104*

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Otherwise, late claims will not be covered.

*6320*

## Payment of Benefits

*6350, 9265*

Benefits will be paid as soon as the necessary proof to support the claim is received.

*6350, 9265*

All benefits are payable to you.

Temporary Disability Benefits will be paid weekly. They will be paid at the end of each week during the period for which benefits are payable. Weekly benefits for a period less than a week will be prorated. This will be done on the basis of the ratio, to 7 days, of the days of eligibility for benefits during the week.

*6350, 9265*

Any unpaid balance at the end of Aetna's liability will be paid within 30 days of receipt by Aetna of the due written proof.

*7693*

Aetna may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

*6350, 9265*

## Contract Not a Substitute for Workers' Compensation Insurance

*7693*

The group contract is not in lieu of and does not affect workers' compensation benefits. However, any workers' compensation benefits are considered other income benefits.

# Additional Information Provided by Aetna Life Insurance Company

## Rehabilitation Appeals Procedure

Aetna has established a procedure for review of a determination by Aetna that an employee be evaluated for and participate in **An Approved Rehabilitation Program**. If you do not agree with Aetna's determination, please follow this procedure:

- Aetna defines a Rehabilitation Appeal as a written request for review of Aetna's determination that you be evaluated for **An Approved Rehabilitation Program** or participate in **An Approved Rehabilitation Program**.
- A Rehabilitation Appeal must be submitted to Aetna within 30 days of the date Aetna provides written notice of its determination.
- An acknowledgment letter will be sent to you within 5 days of Aetna's receipt of the Rehabilitation Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- You will be sent a response within 30 days of Aetna's receipt of the Rehabilitation Appeal. The response will be based on the information provided with, or subsequent to, the Rehabilitation Appeal.
- If additional time is needed to resolve the Rehabilitation Appeal, Aetna will provide a written notification indicating that additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.
- Aetna will keep the records of your Rehabilitation Appeal for 3 years.

*11604*

# Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

*9990*

## Approved Rehabilitation Program

This is a written program approved by Aetna which provides for services and supplies that are intended to enable you to return to work. This program may include, but is not limited to:

- vocational testing;
- vocational training;
- alternative treatment plans such as:
  - support groups;
  - physical therapy;
  - occupational therapy;
  - speech therapy;
- workplace modification to the extent not otherwise provided;
- part time employment; and
- job placement.

A rehabilitation program will cease to be **An Approved Rehabilitation Program** on the date Aetna withdraws, in writing, its approval of the program.

## Consumer Price Index

The CPI-W, Consumer Price Index for Urban Wage Earners and Clerical Workers is published by the United States Department of Labor. If the CPI-W is discontinued or changed, Aetna reserves the right to use a comparable index.

## Injury

An accidental bodily injury.

## Material Duties

These are duties that:

- are normally required for the performance of your **own occupation**; and
- cannot be reasonably: omitted or modified. However, to be at work in excess of 40 hours per week is not a material duty.

## Own Occupation

This is the occupation that you are routinely performing when your period of disability begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed:

- for your specific employer; or
- at your location or work site; and

without regard to your specific reporting relationship.

## Physician

"Physician" means a person who is a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

Regular care of a physician means you are attended by a physician:

- who is not you or related to you;
- who is practicing within the scope of his or her license;
- who has the medical training and clinical expertise suitable to treat your disabling condition; and
- whose treatment is:

  consistent with the diagnosis of the disabling condition; and
  according to guidelines established by medical, research and rehabilitative organizations; and
  administered as often as needed.

## Predisability Earnings

This is the amount of salary or wages you were receiving from an employer participating in this Plan on the day before a period of disability started, calculated on a weekly basis.

If you are paid on an hourly basis, your earnings will be based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per week; but not more than 40 hours per week.

If you do not have regular work hours, the calculation of your earnings will be based on the average number of hours you worked per week during the last 12 calendar months (or during your period of employment if fewer than 12 months); but not more than 40 hours per week.

Included in salary or wages are:

- Commissions averaged over the last 24 months of actual employment or such shorter period if actual employment was for fewer than 24 months.
- Contributions you make through a salary reduction agreement with your Employer to any of the following:

  A Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.

  An IRC 401(k), 403(b) or 457 deferred compensation arrangement.

  An executive nonqualified deferred compensation agreement.

Not included in salary or wages are:

- Awards and bonuses.
- Overtime pay.
- Contributions made by your Employer to any deferred compensation arrangement or pension plan.

## Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at www.aetna.com.

## Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, your Employer may allow you to continue coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

**Premium or Claim Disputes:**
Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

**Notice:**
This notice is for information only and does not become a part or condition of your Certificate.

**AVISO IMPORTANTE**

Para obtener información o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

**Disputas Sobre Primas o Reclamaciones:**
Si surge una disputa concerniente a su prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

**Aviso:**
Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Folleto.

**THE GROUP CONTRACT UNDER WHICH THIS BOOKLET-CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.**

# Summary of Coverage

**Employer:** Parsons Brinkerhoff Group Administration Inc.

**Group Policy:** GP-101979

**SOC:** 2A

**Issue Date:** March 29, 2005

**Effective Date:** January 1, 2005

The benefits shown in this Summary of Coverage are available for you.
Pertaining to employees residing in Arizona:
*NOTICE*: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

Pertaining to Employees residing in New Hampshire:
Aetna shall not be liable for death, injury incurred or disease contracted, as a result of a person's commission of, or attempt to commit, a felony. Aetna shall not be liable for death, injury incurred or disease contracted while a person was engaged in an illegal occupation.

Pertaining to employees residing in New Jersey:
**The group policy and the Booklet-Certificate are subject to the laws of the State of New Jersey.**

Pertaining to employees residing in Ohio:
ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Pertaining to employees residing in West Virginia:
**NOTICE: If you are not satisfied with the coverage under this Plan, you may return this booklet-certificate to your Employer within 10 days of receipt.**

**If you return the booklet-certificate, your coverage (and the coverage for any of your dependents who are covered) will then be terminated under this Plan.**

**If you have not incurred any claims under this Plan, either with respect to yourself or any of your dependents, any required contributions you made for coverage before the date of such termination will be returned to you.**

# Eligibility

You are in an Eligible Class if you are an active full-time or part-time Work Alternative employee of an employer participating in this Plan.

In addition, to be in an Eligible Class you must be:

- scheduled to work on a regular basis at least 40 hours per week during your Employer's work week; or
- scheduled to work on a regular basis at least 17.5 - 39 hours per week during your Employer's work week; and
- classified as a Class 1, 2, or 4 employee; and
- working within the United States.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the date you commence active work for your Employer or, if later, the date you enter the Eligible Class.

# Enrollment Procedure

You will be required to enroll in a manner determined by Aetna and your Employer.

# Effective Date of Coverage

**Employees**

Your coverage will take effect on your Eligibility Date.

*Active Work Rule*: If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until the date you return to work full-time.

You will be considered to be active at work on any of your Employer's scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis. In addition, you will be considered to be active at work on the following days:

- Any day which is not one of your Employer's scheduled work days if you were active at work on the preceding scheduled work day.
- A normal vacation day.

This rule also applies to an increase in your coverage.

# Disability Coverage

## Temporary Disability Income Coverage

**Employees**

After any Elimination Period, this Plan will pay the Temporary Disability Income Benefit during a disability absence. The absence must start while you are covered. A disability absence is time lost from work because of a non-occupational disease or injury. For sole proprietors or partners who cannot be covered by workers' compensation law, this Plan will also cover a disease or injury that arises out of or in the course of any activity in connection with employment as a sole proprietor or partner whether or not on a full time basis. Any reference to Temporary Disability Income Coverage covering only non-occupational disease or injury will not apply to the above mentioned sole-proprietors or partners.

### Elimination Period

Benefits start on the 8th calendar day for a disability period due to disease or injury.

### Weekly Benefit

The following Weekly Benefit is payable for up to the Maximum Weekly Benefit Period of a disability, after any applicable Elimination Period:

| | |
|---|---|
| **Weekly Benefit** | 60% of your Predisability Earnings calculated on a weekly basis |
| **Maximum Weekly Benefit** | $ 1,200 (together with all other income benefits) |
| **Minimum Weekly Benefit** | $ 25 |
| **Maximum Weekly Benefit Period** | 26 weeks |

### Benefits Actually Payable

Any weekly benefit actually payable will be reduced by "other income benefits." In figuring any weekly benefit, other income benefits do not include income from any employer or income from any occupation for compensation or profit. If you work while disabled, any weekly benefit payable is adjusted as described in the following section.

### Benefit Adjustment While Disabled and Working

If, while benefits are payable, you have income from:

- any employer; or
- from any occupation for compensation or profit;

which is more than 20% of your Predisability Earnings, the benefit will be reduced only to the extent the amount of that income and the benefit payable, without any reduction for other income benefits, exceeds 100% of your Predisability Earnings.

Income means income you receive, while disabled and working, from your Employer and from any other employer. However, any income received from another employer will be considered income only to the extent that it exceeds the amount of income you were receiving from such employer immediately before the date a period of disability started.

### Pregnancy Coverage

Benefits are payable on the same basis as for a disease if a female employee, while covered under this Plan, is absent from active work because of a disabling pregnancy-related condition. A physician's certification that the employee is disabled because of the condition will be necessary. Further, Aetna may request any additional evidence it believes is necessary before deciding that benefits are payable.

## Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

## Disclosure

The accident and health insurance evidenced by this Booklet-Certificate provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical as defined by the New York State Insurance Department.

## General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

**KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET-CERTIFICATE**

**THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA**

# Additional Information Provided by Aetna Life Insurance Company

## Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

**If you have questions about benefits or coverage under this plan, call Aetna at the number shown above.**

**If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:**

300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

# Additional Information Provided by

## Parsons Brinckerhoff Group Administration Inc.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

**Employer Identification Number:**
91-0852417

**Plan Number:**
507

**Type of Plan:**
Welfare

**Type of Administration:**
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

**Plan Administrator:**
Parsons Brinckerhoff Group Administration Inc.
C/o Plan Secretary
Human Resources Department
One Penn Plaza
New York, NY 10119

**Agent For Service of Legal Process:**
CT Corporation
111 8th Avenue
New York, NY 10011

**End of Plan Year:**
December 31

**Source of Contributions:**
Employer

**Procedure for Amending the Plan:**
The Employer may amend the Plan from time to time by a written instrument signed by Joan Fabio, Mike Fisher and Tom Defeis.

## Claim Procedures

Your booklet-certificate contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

**Note: If applicable state law requires the Plan to take action on a claim or appeal within a shorter timeframe, the shorter period will apply.**

### Filing Disability Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

You will be notified of an adverse benefit determination not later than 45 days after receipt of the claim. This time period may be extended up to an additional 30 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 45 day period. If a decision cannot be made within this 30 day extension period due to circumstances outside the Plan's control, the time period may be extended up to an additional 30 days, in which case you will be notified before the end of the first 30 day extension period. The notice of extension will explain the standards on which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish that information.

### Filing of an Appeal of an Adverse Benefit Determination for a Disability Claim

You will have 180 days following receipt of an adverse benefit decision to appeal the decision. You will ordinarily be notified of the decision not later than 45 days after the appeal is received. If special circumstances require an extension of time of up to an additional 45 days, you will be notified of such extension during the 45 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

## ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated

Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Note: The codes appearing on the left side of certain blocks of text are required by the State of New York.

# Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.

Ronald A Williams

President

| | |
|---|---|
| Group Policy: | GP-101979 |
| Cert. Base: | 1 |
| Issue Date: | June 5, 2006 |
| Effective Date: | January 1, 2005 |

*0020*

# Long Term Disability Coverage

This Plan will pay a Monthly Benefit for a period of disability caused by a disease or **injury**. There is an elimination period. (This is the length of time during a period of disability that must pass before benefits start.)

## Test of Disability

From the date that you first become disabled and until Monthly Benefits are payable for 24 months, you will be deemed to be disabled on any day if:

- you are not able to perform the **material duties** of your **own occupation** solely because of: disease or **injury**; and
- your work earnings are 80% or less of your **adjusted predisability earnings**.

After the first 24 months that any Monthly Benefit is payable during a period of disability, you will be deemed to be disabled on any day if you are not able to work at any **reasonable occupation** solely because of:

- disease; or
- **injury**.

If your **own occupation** requires a professional or occupational license or certification of any kind, you will not be deemed to be disabled solely because of the loss of that license or certification.

*11201, 11519*

## Monthly Benefit

The Scheduled Monthly LTD Benefit, the Maximum Monthly Benefit, and the Minimum Monthly Benefit are shown on the Summary of Coverage.

The monthly benefit is an amount based on your monthly predisability earnings. Other income benefits, as defined later, are taken into account.

- If no other income benefits are payable for a given month:

  The monthly benefit payable under this Plan for that month will be the lesser of:

  the Scheduled Monthly LTD Benefit; and

  the Maximum Monthly Benefit.
- If other income benefits are payable for a given month:

  The monthly benefit payable under this Plan for that month will be the lesser of:

  the Scheduled Monthly LTD Benefit; and

  the Maximum Monthly Benefit;

  minus all other income benefits, but not less than the Minimum Monthly Benefit.

*7264*

## When Benefits Are Payable

Monthly benefits will be payable if a period of disability:

- starts while you are covered; and
- continues during and past the elimination period.

These benefits are payable after the elimination period ends for as long as the period of disability continues.

*7265*

## A Period of Disability

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under this Plan. You must be under the regular care of a **physician**. (You will not be deemed to be under the regular care of a **physician** more than 31 days before the date he or she has seen and treated you in person for the disease or **injury** that caused the disability.)

Your period of disability ends on the first to occur of:

- The date Aetna finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date Aetna finds that you have withheld information which indicates you are performing, or are capable of performing, the duties of a **reasonable occupation**.
- The date you refuse to be examined by, or cooperate with, an independent **physician** or a licensed or certified health care practitioner, as requested.
- The date you cease to be under the regular care of a **physician**.
- The date an independent medical exam report or functional capacity evaluation fails to confirm your disability.
- The date you reach the end of your Maximum Benefit Duration.
- The date you are not undergoing **effective treatment for alcoholism or drug abuse**, if your disability is caused to any extent by alcoholism or drug abuse.
- The date you refuse to cooperate with or accept:

  changes made to a work site or job process to suit your identified medical limitations; or

  adaptive equipment or devices designed to suit your identified medical limitations;

  which would enable you to perform your **own occupation** or a **reasonable occupation** (if you are receiving benefits for being unable to work any **reasonable occupation**) and provided that a **physician** agrees that such changes or adaptive equipment suit your medical limitations.
- The date you refuse to receive treatment recommended by your attending **physician** that in Aetna's opinion would: cure; correct; or limit your disability.
- The date your condition would permit you to work, or increase the number of hours you work, or the number or type of duties you perform in your **own occupation**, but you refuse to do so.
- The date of your death.
- The day after Aetna determines you are able to participate in an **Approved Rehabilitation Program** and you refuse to do so.

*7263, 7680, 11205-2*

A period of disability will end after 24 months if it is determined that the disability is primarily caused by:

- a Mental Health or Psychiatric condition, including physical manifestations of these conditions, but excluding those conditions with demonstrable, structural brain damage; or
- Alcohol and/or Drug Abuse.

There are two exceptions which apply if you are confined as an inpatient in a **hospital** or **treatment facility** for treatment of that condition at the end of such 24 months.

- If the inpatient confinement lasts less than 30 days, the period of disability will cease when you are no longer confined.
- If the inpatient confinement lasts 30 days or more, the period of disability may continue until 90 days after the date you have not been so continuously confined.

*11521*

The Separate Periods of Disability section does not apply beyond 24 months to periods of disability which are subject to the above paragraph.

## How Separate Periods of Disability Are Treated

Once a period of disability has ended, any new period of disability will be treated separately.

However, 2 or more separate periods of disability due to the same or related causes will be deemed to be one period of disability and only one elimination period will apply if:

the separation occurs during the elimination period and the periods are separated by less than 15 days in a row of work.

the separation occurs after the elimination period and the periods are separated by less than 6 months in a row of work.

The first period will not be included if it began while you were not covered under this LTD Plan.

If you become eligible for coverage under any other group long term disability benefits plan carried or sponsored by your Employer, this Separate Periods of Disability section will cease to apply to you.

*7684, 7537-1*

## Other Income Benefits

*7537*

*7537, 7537-2*

They are:

- 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.

- Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:

  Unemployment compensation benefits.

  Temporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.

  Automobile no-fault wage replacement benefits to the extent required by law.

  Statutory disability benefits.

  Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.

*7537, 7537-2*
*7537, 7537-2*

Veterans' benefits.

- Statutory disability benefits.

- Disability or unemployment benefits under any plan or arrangement of coverage (other than group life insurance if they would reduce the amount of group life insurance):

  as a result of employment by or association with the Employer; or

  as a result of membership in or association with any group, association, union or other organization.

*7537, 7537-2*

This includes both, plans that are insured and those that are not.

- Unreduced retirement benefits for which you are or may become eligible under your Employer's group pension plan at the later of:

  age 62, and

  the Plan's Normal Retirement Age,

*7608*

but only to the extent that such benefits were paid for by your Employer.

- Voluntarily elected retirement benefits received under a group pension plan provided by your Employer, but only to the extent that such benefits were paid for by your Employer.

*7607*

- Disability payments which result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.

*7537*

- Disability benefits under any group mortgage or group credit disability plan.

*7537*

Other income benefits include those, due to your disability or retirement, which are payable to: you; your spouse; your children; your dependents.

*7537*

## Effect of Increases In Other Income Benefits On Monthly Benefits

Increases in the level of other income benefits due to the following will be considered "other income benefits":

- a change in the number of your family members;
- a recomputation or recalculation to correct or adjust your benefit level as first established for the period of disability; or
- a change in the severity of your disability.

There may be cost of living increases in the level of other income benefits received from a governmental source during a period of disability. These increases will not be deemed to be "other income benefits."

There may be cost of living or general increases in the level of other income benefits from a non-governmental source during a period of disability. These increases will not be considered other income benefits to the extent they are based on the annual average increase in the **Consumer Price Index**.

*7539, 7539-1*

## Other Income Benefits Which Do Not Reduce Monthly Benefits

The amount of any retirement or disability benefits you were receiving from the following sources before the date you become disabled under this LTD Plan will not reduce your monthly benefits:

- military and other government service pensions;
- retirement benefits from a prior employer; and
- veterans' benefits for service related disabilities; and

- individual disability income policies; and
- Federal Social Security Act.

Also, the amount of any income or other benefits you receive from the following sources will not reduce your monthly benefits:

- profit sharing plans;
- thrift plans;
- 401(k) plans;
- Keogh plans;
- employee stock option plans;
- tax sheltered annuity plans;
- severance pay;
- individual disability income policies;
- individual retirement accounts (IRAs; or
- a retirement plan sponsored by your employer, to the extent that payments are due to any amount which has been rolled over or transferred from a prior, unrelated employer's retirement plan.

*7539*

Aetna will determine other income benefits as follows:

### Lump Sum and Periodic Payments From Any Other Income Benefits

Any lump sum or periodic other income (described elsewhere in this certificate) that you receive will be prorated on a monthly basis over the period of time for which the payment was made. If a period of time is not indicated, Aetna will prorate the payments over your expected lifetime, as determined by Aetna.

That part of the lump sum or periodic payment that is for disability will be counted, if it is specifically apportioned or identified as such.

Any of these "Other Income Payments" that date back to a prior date may be allocated on a retroactive basis.

### Estimated Payments

The amount of other income benefits for which you appear to be eligible will be estimated, unless you have signed and returned a reimbursement agreement to Aetna. This agreement contains your promise to repay Aetna for any overpayment of benefits made to you.

If other income benefits are estimated, your monthly benefit will be adjusted when we receive proof:

- of the exact amount awarded; or
- that benefits have been denied after review at the highest administrative level.

Aetna will pay you if any underpayment in your monthly benefit results. You will have to repay Aetna if any overpayment results. When Aetna has to take legal action against you to recover any overpayment, you will also have to pay Aetna's reasonable attorney's fees and court costs, if Aetna prevails.

*7538, 11206*

## Required Proof of Income

Aetna has the right to require proof that:

- you, your spouse, child, or dependent has made application for all other income benefits which you or they are, or may be, eligible to receive relative to your disability and has made a timely appeal of any denial through the highest Administrative level;

timely appeal means making such an appeal as required, but in no case later than 60 days from the latest denial;
- the person has furnished proof needed to obtain other income benefits, which includes, but is not limited to, Workers' Compensation Benefits;
- the person has not waived any other income benefits without Aetna's written consent; and
- the person has sent copies of the documents to Aetna showing the effective dates and the amounts of other income benefits.

In addition to the above, for purposes of Federal Social Security, when a timely application for benefits has been made and denied, a request for reconsideration must be made within 60 days after the denial, unless Aetna states, in writing, that it does not require you to do so. Also, if the reconsideration is denied, an application for a hearing before an Administrative Law Judge must be made within 60 days of that denial unless Aetna relieves you of that obligation.

Aetna also requires proof:

- of income you receive from any occupation for compensation or profit; and
- if your income from any such occupation is 80% or less of your **adjusted predisability earnings**, proof that you are unable, due to disease or **injury**, to earn more than 80% of your **adjusted predisability earnings**.

You do not have to apply for:

- retirement benefits paid only on a reduced basis; or
- disability benefits under group life insurance if they would reduce the amount of group life insurance;

but, if you do apply for and receive these benefits, they will be deemed to be other income benefits for which proof is required.

If you do not furnish proof of other income benefits, Aetna reserves the right to suspend or adjust benefits by the estimated amount of such other income benefits.

*7686; 7543-1*

## Approved Rehabilitation Program

Aetna retains the right to evaluate you for participation in an **Approved Rehabilitation Program**.

If, in Aetna's judgment, you are able to participate, Aetna may, in its sole discretion require you to participate in an **Approved Rehabilitation Program**.

This Plan will pay for all services and supplies, approved in advance by Aetna, needed in connection with such participation; except for those for which you can otherwise receive reimbursement from any third party payor, including any governmental benefits to which you may be entitled.

*7540, 7687, 7540-1*

## Exclusions

Long Term Disability Coverage does not cover any disability that:

- is due to intentionally self-inflicted **injury**.
- results from your commission of, or attempt to commit, a felony.
- results from driving an automobile while intoxicated. ("Intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under state law.)
- is due to war or any act of war (declared or not declared).
- is due to participating in an insurrection, rebellion, riot, or civil commotion.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- the person will not be deemed to be disabled; and
- no benefits will be payable.

*7541, 7541-1*

## Pre-existing Conditions

No benefit is payable for any disability that is caused by or contributed to by a "pre-existing condition" and starts before the end of the first 12 months following your effective date of coverage.

A disease or **injury** is a pre-existing condition if, during the 3 months before your effective date of coverage:

- it was diagnosed or treated; or
- services were received for the diagnosis or treatment of the disease or **injury**; or
- you took drugs or medicines prescribed or recommended by a **physician** for that condition.

*7541-2*

# General Information About Your Coverage

**(including information about Termination of Coverage and the Effect of Prior Coverage)**

## Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Ceasing active work will be deemed to be cessation of employment. If you are not at work due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or **injury**, your employment may be continued until stopped by your Employer, but not beyond 12 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment will be deemed to cease on your last full day of active work before the start of the lay-off or leave of absence.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

## Benefits May Continue After Termination

*6080*

If your coverage ceases during a period of disability which began while you had coverage, benefits will be available as long as your period of disability continues.

## Reinstatement of Coverage

If your coverage terminates, you may again become covered in accordance with the terms of this Plan; except that:

- If:

  you return to active work within 6 months of the date coverage terminated; and

  you request coverage from your Employer within 31 days of your return to active work;

any Limitation as to a pre-existing condition will apply only to the extent it would have applied if your coverage had not terminated. Also, any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

- If:

  you return to active work between the 7th and the 24th month following the date coverage terminated; and

  you request coverage from your Employer within 31 days of your return to active work;

any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

*7690*

## How "Prior Coverage" Affects Coverage Under This Plan

If the coverage of any person under this Plan replaces any prior coverage of the person, the following will apply.

"Prior coverage" is any plan of group long term disability coverage that has been replaced by coverage under part or all of this Plan. It must have been sponsored by your Employer who is participating in this Plan. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group insurance plan.

A person's coverage under this Plan replaces and supersedes any prior coverage. It will be in exchange for everything under such prior coverage except coverage will not be available as to a particular period of disability for which a benefit is available or would be available under the prior coverage in the absence of coverage under this Plan.

As stated earlier, this Plan has a Limitation as to a disability caused by a pre-existing condition.

However, if:

- you had prior coverage on the day before Long Term Disability Coverage took effect; and
- you became covered for this LTD Plan on the date it takes effect;

such Limitation applies only until a continuous period of coverage under the prior coverage and this LTD Plan are equal to the lesser of:

- 12 months; and
- any period of limitation as to a pre-existing condition remaining under the prior coverage.

Where the Limitation no longer applies, the amount of monthly benefit and the maximum period for which benefits will be payable, as to a period of disability caused by such pre-existing condition, will be as provided in this LTD Plan.

In no event will:

- A benefit be payable as to a period of disability caused by a pre-existing condition, if the disability is excluded by any other terms of this LTD Plan.
- A condition be considered to be a pre-existing condition under this LTD Plan if it was not a pre-existing condition under the prior coverage.

*6051*

**Survivor Benefit**

If you die while disabled, a single, lump sum benefit will be paid under this provision if:

- there is an Eligible Survivor as defined below; and
- a Monthly Benefit was payable under this Plan.

The benefit amount will be:

- 3 times the Monthly Benefit, not reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you are eligible for one full Monthly Benefit, however, the benefit will be:

- 3 times the Monthly Benefit, not reduced by other income benefits, for which you would have been eligible if you had not died, for the first full month after the month in which you die.

An Eligible Survivor is:

- Your legally married spouse at the date of your death.
- If there is no such spouse, your biological or legally adopted child who, when you die:

  is not married; and

  is depending mainly on you for support; and

  is under age 25. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed prior to age 25.

**How the Survivor Benefit Will Be Paid**

The benefit will be paid as soon as the necessary written proof of your death and disability status is received.

The benefit will be paid to your eligible surviving spouse, if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

If Monthly Benefit payments are made in amounts greater than the Monthly Benefits that you are entitled to receive, Aetna has the right to first apply the survivor benefit to any such overpayment.

Aetna, in its capacity as the provider of administrative services to this Plan, may pay the benefit to anyone who, in Aetna's opinion, is caring for and supporting the eligible survivor; or, if proper claim is made, to an eligible survivor's legally appointed guardian or committee.

**Assignment of Insurance**
*7542*

Coverage may be assigned only with the consent of Aetna.

**How and When To Report Your Claim**

You are required to submit a claim to Aetna by following the procedure chosen by your Employer. If the procedure requires that claim forms be submitted, they may be obtained at your place of employment or from Aetna. Your claim must give proof of the nature and extent of the loss. Aetna may require copies of documents to support your claim,

including data about any other income benefits. You must also provide Aetna with authorizations to allow it to investigate your claim and your eligibility for and the amount of other income benefits.

You must furnish such true and correct information as Aetna may reasonably request.

The deadline for filing a claim for benefits is 90 days after the end of the elimination period. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will be accepted if you file as soon as reasonably possible. Otherwise, late claims will not be covered.

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## How Benefits Will Be Paid

Benefits will be paid to you at the end of each calendar month during the period for which benefits are payable. Benefits for a period less than a month will be prorated. This will be done on the basis of the ratio, to 30 days, of the days of eligibility for benefits during the month.

Any unpaid balance at the end of Aetna's liability will be paid within 30 days of receipt by Aetna of the due written proof.

Aetna may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

*7543*

## Examinations and Evaluations

*7543*

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while that claim is pending or payable. This will be done at Aetna's expense.

## Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

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## Recovery of Overpayments

If payments are made in amounts greater than the benefits that you are entitled to receive, Aetna has the right to do any one or all of the following:

- to require you to return the overpayment on request;
- to stop payment of benefits until the overpayment is recovered;
- to take any legal action needed to recover the overpayment; and
- to place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

If the overpayment:

- occurs as a result of your receipt of other income benefits for the same period for which you have received a benefit under this Plan; and
- to obtain such other income benefits, advocate or legal fees were incurred;

Aetna will exclude from the amount to be recovered, such advocate or legal fees; provided you return the overpayment to Aetna within 30 days of Aetna's written request for the overpayment. If you do not return the overpayment to Aetna within such 30 days, such fees will not be excluded; you will remain liable for repayment of the total overpaid amount.

Examples of "other income" referred to in the preceding paragraph are:

- Workers' compensation.
- Federal Social Security benefits.

*7543*

## Contract Not a Substitute for Workers' Compensation Insurance

*7693*

The group contract is not in lieu of and does not affect workers' compensation benefits. However, any workers' compensation benefits are considered other income benefits.

## General Provisions

The following additional provisions apply to your coverage.

You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna. Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

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# Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

## Adjusted Predisability Earnings

This is your **predisability earnings** plus any increase made on each January 1, starting on the January 1 following 12 months of a period of disability. The increase on each such January 1 will be by the percentage increase in the **Consumer Price Index**, rounded to the nearest tenth; but not by more than 10%.

## Approved Rehabilitation Program

This is a written program approved by Aetna which provides for services and supplies that are intended to enable you to return to work. This program may include, but is not limited to:

- vocational testing;
- vocational training;
- alternative treatment plans such as:
  - support groups;
  - physical therapy;
  - occupational therapy;
  - speech therapy;
- workplace modification to the extent not otherwise provided;
- part time employment; and
- job placement.

A rehabilitation program will cease to be **An Approved Rehabilitation Program** on the date Aetna withdraws, in writing, its approval of the program.

## Consumer Price Index

The CPI-W, Consumer Price Index for Urban Wage Earners and Clerical Workers is published by the United States Department of Labor. If the CPI-W is discontinued or changed, Aetna reserves the right to use a comparable index.

## Effective Treatment of Alcoholism or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means solely treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means primarily providing an environment free of alcohol or drugs.

## Hospital
This is an institution that:

- mainly provides, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons; and
- is supervised by a staff of **physicians**; and
- provides 24 hour a day registered nursing (RN) service; and
- is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

An institution which does not provide complete surgical services, but which meets all the other tests listed above, will also be deemed a hospital if:

- it provides services chiefly to patients all of whom have conditions related either by a medical specialty field or a specific disease category; and
- while confined, the patient is under regular therapeutic treatment by a **physician** for the **injury** or disease.

## Injury
An accidental bodily injury.

## Material Duties
These are duties that:

- are normally required for the performance of your **own occupation**; and
- cannot be reasonably: omitted or modified. However, to be at work in excess of 40 hours per week is not a material duty.

## Own Occupation
This is the occupation that you are routinely performing when your period of disability begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed:

- for your specific employer; or
- at your location or work site; and

without regard to your specific reporting relationship.

## Physician
"Physician" means a person who is a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

Regular care of a physician means you are attended by a physician:

- who is not you or related to you;
- who is practicing within the scope of his or her license;
- who has the medical training and clinical expertise suitable to treat your disabling condition; and
- whose treatment is:

  consistent with the diagnosis of the disabling condition; and
  according to guidelines established by medical, research and rehabilitative organizations; and
  administered as often as needed.

## Predisability Earnings

This is the amount of salary or wages you were receiving from an employer participating in this Plan on the day before a period of disability started, calculated on a monthly basis.

It will be figured from the rule below that applies to you.

If you are paid on an annual contract basis, your monthly salary is 1/12th of your annual contract salary.

If you are paid on an hourly basis, the calculation of your monthly wages is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month; but not more than 173 hours per month.

If you do not have regular work hours, the calculation of your monthly salary or wages is based on the average number of hours you worked per month during the last 12 calendar months (or during your period of employment if fewer than 12 months); but not more that 173 hours per month.

Included in salary or wages are:

- Commissions averaged over the last 12 months of actual employment or such shorter period if actual employment was for fewer than 12 months.
- Contributions you make through a salary reduction agreement with your Employer to any of the following:

  An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.

  An IRC 401(k), 403(b), or 457 deferred compensation arrangement.

  An executive nonqualified deferred compensation agreement.

Not included in salary or wages are:

- Awards and bonuses.
- Overtime pay.
- Contributions made by your Employer to any deferred compensation arrangement or pension plan.

A retroactive change in your rate of earnings will not result in a retroactive change in coverage.

## Reasonable Occupation

This is any gainful activity for which you are; or may reasonably become; fitted by: education; training; or experience; and which results in; or can be expected to result in; an income of more than 80% of your **adjusted predisability earnings.**

## Treatment Facility

This is an institution (or distinct part thereof) that is for the treatment of alcoholism or drug abuse and which meets fully every one of the following tests:

- It is primarily engaged in providing on a full-time inpatient basis, a program for diagnosis, evaluation, and treatment of alcoholism or drug abuse.
- It provides all medical detoxification services on the premises, 24 hours a day.
- It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the alcoholism or drug abuse, on a 24 hour daily basis. Also, it provides, or has an agreement with a **hospital** in the area to provide, any other medical services that may be required during the treatment period.

- On a continuous 24 hour daily basis, it is under the supervision of a staff of **physicians**, and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.
- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a **physician.**
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

# Additional Information Provided by Aetna Life Insurance Company

## Rehabilitation Appeals Procedure

Aetna has established a procedure for review of a determination by Aetna that an employee be evaluated for and participate in **An Approved Rehabilitation Program**. If you do not agree with Aetna's determination, please follow this procedure:

- Aetna defines a Rehabilitation Appeal as a written request for review of Aetna's determination that you be evaluated for **An Approved Rehabilitation Program** or participate in **An Approved Rehabilitation Program.**
- A Rehabilitation Appeal must be submitted to Aetna within 30 days of the date Aetna provides written notice of its determination.
- An acknowledgment letter will be sent to you within 5 days of Aetna's receipt of the Rehabilitation Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- You will be sent a response within 30 days of Aetna's receipt of the Rehabilitation Appeal. The response will be based on the information provided with, or subsequent to, the Rehabilitation Appeal.
- If additional time is needed to resolve the Rehabilitation Appeal, Aetna will provide a written notification indicating that additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.
- Aetna will keep the records of your Rehabilitation Appeal for 3 years.

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**Confidentiality Notice**

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at www.aetna.com.

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

**Premium or Claim Disputes:**
Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

**Notice:**
This notice is for information only and does not become a part or condition of your Certificate.

**AVISO IMPORTANTE**

Para obtener información o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

**Disputas Sobre Primas o Reclamaciones:**
Si surge una disputa concerniente a su prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

**Aviso:**
Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Folleto.

**THE GROUP CONTRACT UNDER WHICH THIS BOOKLET-CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.**

# Summary of Coverage

| | |
|---|---|
| **Employer:** | Parsons Brinckerhoff Group Administration Inc. |
| **Group Policy:** | GP-101979 |
| **SOC:** | 1A |
| **Issue Date:** | March 29, 2005 |
| **Effective Date:** | January 1, 2005 |

The benefits shown in this Summary of Coverage are available for you.

Pertaining to employees residing in Arizona:
*NOTICE*: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

Pertaining to employees residing in New Hampshire:
Aetna shall not be liable for death, injury incurred or disease contracted, as a result of a person's commission of, or attempt to commit, a felony. Aetna shall not be liable for death, injury incurred or disease contracted while a person was engaged in an illegal occupation.

Pertaining to employees residing in New Jersey:
**The group policy and the Booklet-Certificate are subject to the laws of the State of New Jersey.**

Pertaining to employees residing in Ohio:
ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Pertaining to employees residing in West Virginia:
**NOTICE: If you are not satisfied with the coverage under this Plan, you may return this booklet-certificate to your Employer within 10 days of receipt.**

**If you return the booklet-certificate, your coverage (and the coverage for any of your dependents who are covered) will then be terminated under this Plan.**

**If you have not incurred any claims under this Plan, either with respect to yourself or any of your dependents, any required contributions you made for coverage before the date of such termination will be returned to you.**

# Eligibility

**Employees**

You are in an Eligible Class if you are an active Class 1 or 2, full-time or part-time Work Alternative employee of an Employer participating in this Plan.

In addition, to be in an Eligible Class you must be:

- scheduled to work on a regular basis at least 40 hours per week during your Employer's work week; or
- scheduled to work on a regular basis at least 17.5 - 39 hours per week during your Employer's work week; and
- working within the United States.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the date you commence active work for your Employer or, if later, the date you enter the Eligible Class.

# Enrollment Procedure

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll within 31 days of your Eligibility Date.

The Disability coverage is fully contributory. You must pay the required contributions in full. Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change.

# Effective Date of Coverage

**Employees**

Your coverage will take effect on your Eligibility Date.

*Active Work Rule*: If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until the date you return to work full-time.

You will be considered to be active at work on any of your Employer's scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis. In addition, you will be considered to be active at work on the following days:

- Any day which is not one of your Employer's scheduled work days if you were active at work on the preceding scheduled work day.
- A normal vacation day.

This rule also applies to an increase in your coverage.

# Disability Coverage

## Long Term Disability Benefits

**Employees**

*Elimination Period*: The greater of:

- first 6 months of a period of disability; and
- the period of time when disability benefits are payable from any short term disability benefits with the exception of any statutory disability benefits, accumulated sick time or salary continuation program sponsored by your Employer.

| | |
|---|---|
| Option 1:<br>Scheduled Monthly LTD Benefit | 50% of your monthly predisability earnings. |
| Option 2:<br>Scheduled Monthly LTD Benefit | 60% of your monthly predisability earnings. |
| Option 1:<br>Maximum Monthly Benefit Under this Plan (together with all other income benefits) | $ 5,000 |
| Option 2:<br>Maximum Monthly Benefit Under this Plan (together with all other income benefits) | $ 7,500 |
| For Option 1 & 2:<br>Minimum Monthly Benefit | The greater of:<br>(a) $ 100; and<br>(b) 10% of your Gross Monthly LTD Benefit Level. |

You may elect coverage under any one of the available options shown above for Long Term Disability coverage. Once you have made a selection, if you wish to choose a different option, your Employer will provide you with the information on when and how you can make that change.

### Evidence Requirements

If you elect to increase your Disability Coverage, you can become insured for the new amount only if you submit evidence of good health at your own expense to Aetna and such evidence is approved by Aetna. This applies even if Aetna has approved evidence of your good health in the past.

## Benefits Actually Payable

Any monthly benefit actually payable will be reduced by "other income benefits." In figuring any monthly benefit, other income benefits do not include income from any employer or income from any occupation for compensation or profit. If you work while disabled, any monthly benefit payable is adjusted as described in the following section.

***Benefit Adjustment While Disabled and Working***

If, while monthly benefits are payable, you have income from:

- any employer; or
- any occupation for compensation or profit;

which is more than 20% of your adjusted predisability earnings; the monthly benefit will be adjusted as follows:

During the first 12 months that you have such income, the monthly benefit will be reduced only to the extent the sum of the amount of that income and the monthly benefit payable, without any reduction for other income benefits, exceeds 100% of your adjusted predisability earnings.

Thereafter, the monthly benefit will be the product of the following:

(A divided by B) x C where:

A = Your adjusted predisability earnings minus such income.
B = Your adjusted predisability earnings.
C = The monthly benefit payable.

Income means income you receive, while disabled and working, from your Employer and from any other employer. However, any income received from another employer will be considered income only to the extent that it exceeds the amount of income you were receiving from such employer immediately before the date a period of disability started.

## Maximum Benefit Duration*

Your period of disability will end on the later of:

- The calendar month in which you reach normal retirement age, as determined by the 1983 Amended Social Security Normal Retirement Age; and
- The expiration of the number of months of disability, after the elimination period is met as figured from the following Schedule, if your period of disability starts on or after the date you reach age 62:

***Maximum Benefit Duration Schedule***

| Age When Period of Disability Starts | Months of Disability |
|---|---|
| 62 but less than 63 | 42 months |
| 63 but less than 64 | 36 months |
| 64 but less than 65 | 30 months |
| 65 but less than 66 | 24 months |
| 66 but less than 67 | 21 months |
| 67 but less than 68 | 18 months |
| 68 but less than 69 | 15 months |
| 69 and over | 12 months |

***1983 Amended Social Security Normal Retirement Age***

| Year of Birth | Normal Retirement Age |
|---|---|
| Before 1938 | 65 |

| | |
|---|---|
| 1938 | 65 and 2 months |
| 1939 | 65 and 4 months |
| 1940 | 65 and 6 months |
| 1941 | 65 and 8 months |
| 1942 | 65 and 10 months |
| 1943 to 1954 | 66 |
| 1955 | 66 and 2 months |
| 1956 | 66 and 4 months |
| 1957 | 66 and 6 months |
| 1958 | 66 and 8 months |
| 1959 | 66 and 10 months |
| After 1959 | 67 |

* Unless your period of disability ends earlier for one or more of the reasons stated in your Booklet-Certificate.

### Pregnancy Coverage

Benefits are payable on the same basis as for a disease if a female employee, while covered under this Plan, is absent from active work because of a disabling pregnancy-related condition. A physician's certification that the employee is disabled because of the condition will be necessary. Further, Aetna may request any additional evidence it believes is necessary before deciding that benefits are payable.

If, during the 3 months before coverage took effect, services are rendered or supplies are received in connection with a pregnancy or a pregnancy is confirmed, the pregnancy is a pre-existing condition whether or not the pregnancy commenced during that 3 month period.

## Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

## Disclosure

The disability coverage provides periodic benefit payments to help replace income when the insured is unable to work as a result of illness or injury.

The accident and health insurance evidenced by this Booklet-Certificate provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical as defined by the New York State Insurance Department.

# General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

**KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET-CERTIFICATE**

**THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA**

# Additional Information Provided by Aetna Life Insurance Company

## Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

**If you have questions about benefits or coverage under this plan, call Aetna at the number shown above.**

**If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:**

300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

# Additional Information Provided by

## Parsons Brinckerhoff Group Administration Inc.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

**Employer Identification Number:**
91-0852417

**Plan Number:**
507

**Type of Plan:**
Welfare

**Type of Administration:**
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

**Plan Administrator:**
Parsons Brinckerhoff Group Administration Inc.
C/o Plan Secretary
Human Resources Department
One Penn Plaza
New York, NY 10011

**Agent For Service of Legal Process:**
CT Corporation
111 8th Avenue
New York, NY 10011

**End of Plan Year:**
December 31

**Source of Contributions:**
Employer and Employee

**Procedure for Amending the Plan:**
The Employer may amend the Plan from time to time by a written instrument signed by Joan Fabio, Mike Fisher and Tom Defeis.

## Claim Procedures

Your booklet-certificate contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

**Note: If applicable state law requires the Plan to take action on a claim or appeal within a shorter timeframe, the shorter period will apply.**

### Filing Disability Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

You will be notified of an adverse benefit determination not later than 45 days after receipt of the claim. This time period may be extended up to an additional 30 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 45 day period. If a decision cannot be made within this 30 day extension period due to circumstances outside the Plan's control, the time period may be extended up to an additional 30 days, in which case you will be notified before the end of the first 30 day extension period. The notice of extension will explain the standards on which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish that information.

### Filing of an Appeal of an Adverse Benefit Determination for a Disability Claim

You will have 180 days following receipt of an adverse benefit decision to appeal the decision. You will ordinarily be notified of the decision not later than 45 days after the appeal is received. If special circumstances require an extension of time of up to an additional 45 days, you will be notified of such extension during the 45 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

## ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining

agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# Aetna Life Insurance Company

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS
LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity, or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees

or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE
However, persons owning such policies are NOT protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); unallocated annuity contracts (which give rights to group contractholders, not individuals); unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE
The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the Association will not pay more than $ 300,000 in health insurance benefits, $ 300,000 in present value of annuity benefits, or $ 300,000 in life insurance death benefits or net cash surrender values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $ 1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

# Aetna Life Insurance Company

CALIFORNIA LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
SUMMARY DOCUMENT AND DISCLAIMER

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guaranty Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

DISCLAIMER

The California Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life and Health Insurance Guaranty Association
P.O. Box 16860
Beverly Hills, CA 90209 or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

**COVERAGE**
Generally, individuals will be protected by the California Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**
However, persons holding such policies are not protected by this Guaranty Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guaranty Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guaranty rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

**LIMITS ON AMOUNT OF COVERAGE**
The Act limits the Association to pay benefits as follows:

**LIFE AND ANNUITY BENEFITS**
- 80% of what the life insurance company would owe under a life policy or annuity contract up to $ 100,000 in cash surrender values, $ 100,000 in present value of annuities, or $ 250,000 in life insurance death benefits.
- A maximum of $ 250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

**HEALTH BENEFITS**
- A maximum of $ 200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

**PREMIUM SURCHARGE**
Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

# Aetna Life Insurance Company

SUMMARY OF THE LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

INTRODUCTION

Residents of Colorado who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Life and Health Insurance Protection Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

IMPORTANT DISCLAIMER

The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

SUMMARY

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Protection Association if they live in this state and hold a life or health insurance contract, or annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

EXCLUSIONS FROM COVERAGE
Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rates yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991 and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

LIMITS ON AMOUNT OF COVERAGE
The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- $ 300,000 in net life insurance death benefits and no more than $ 100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - $ 100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values: $ 300,000 for disability insurance; or $ 500,000 for basic hospital, medical and surgical, or major medical insurance;
- $ 100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

- with respect to each payee of a structured settlement annuity, $ 100,000 in present value annuity benefits in the aggregate, including net cash surrender and net cash withdrawal values.

The Association shall not be liable to expend more than $ 300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the association shall not exceed $ 500,000 with respect to any one individual.

This Information is Provided By:

Life and Health Insurance Protection Association
P.O. Box 480025
Denver, CO 80248-0025
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
(303) 894-7499

# Aetna Life Insurance Company

DISTRICT OF COLUMBIA
LIFE & HEALTH INSURANCE GUARANTY
ASSOCIATION ACT OF 1992

**SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE**

Residents of the District of Columbia who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted below.

**DISCLAIMER**

***The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.***

***The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Insurance Commissioner will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law for using the existence of the association or its coverage to sell you an insurance policy.***

***You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer.***

***Policyholders with additional questions may contact:***

**Mr. Robert M. Willis**
**Executive Director**
**District of Columbia Life and Health Insurance Guaranty Association**
**1200 G Street, N.W.**
**Suite 800**
**Washington, D.C. 20005**
**(202) 434-8771**
**Fax: (202) 347-2990**

**Mr. Lawrence H. Mirel**
**Acting Commissioner**
**District of Columbia Department of Insurance and Securities Regulation**
**810 First Street, N.E.**
**Suite 701**
**Washington, D.C. 20002**
**(202) 727-8000**
**Fax: (202) 535-1196**

The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside of that state of incorporation);
- the insurer was not authorized to do business in the District of Columbia; or
- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital service plan, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- interest rate guarantees which exceed certain statutory limitations;
- dividends, experience rating credits or fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder; or for
- unallocated annuity contracts.

**LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of either the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or, with respect to any one life, regardless of the number of policies, contracts, or certificates, in the case of life insurance, $ 300,000 in death benefits but not more than $ 100,000 in net cash surrender or withdrawal values; in the case of health insurance, $ 100,000 in health insurance benefits; and, with respect to annuities, $ 300,000 in the present value of annuity benefits. Finally, in no event is the Guaranty Association liable for more than $ 300,000 with respect to any one individual.

# Aetna Life Insurance Company

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE HAWAII
LIFE AND DISABILITY INSURANCE
GUARANTY ASSOCIATION ACT

Residents of Hawaii who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**DISCLAIMER**

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Hawaii Life and Disability Insurance Guaranty Association
P.O. Box 4068
Honolulu, Hawaii 96812

Department of Commerce & Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not a member insurer of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Guaranty Association is obligated to pay out: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the Association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in disability insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits --again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

# Aetna Life Insurance Company

**SUMMARY OF THE IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS**

Residents of Idaho who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Idaho Life and Health Insurance Guaranty Association. The purpose of the Association is to assure policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who reside in Idaho and, in some cases, to keep coverage in force. However, the protection provided by these insurers through the Association is limited and is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

**IMPORTANT DISCLAIMER**

The Idaho Life and Health Insurance Guaranty Association does not provide coverage for all types of policies. In addition, coverage may be subject to substantial limitations or exclusions, and require continued residency in Idaho. You should not rely on coverage by the Idaho Life and Health Insurance Guaranty Association in selecting an insurance company or an insurance policy.

COVERAGE IS NOT PROVIDED BY THE IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION FOR YOUR POLICY OR CONTRACT OR ANY PORTION OF IT UNDER WHICH THE RISK IS BORNE BY YOU - THE POLICYHOLDER.

Insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy. When you are selecting an insurance company, you should not rely on protections provided by the Guaranty Association.

**This information is provided by:**

**State of Idaho Department of Insurance**
**700 West State Street**
**P.O. Box 83720**
**Boise, Idaho 83720-0043**
**208-334-4250**
**1-800-721-3272**

**Idaho Life and Health Insurance Guarantee Association**
**8324 Northview, Suite 104**
**Boise, Idaho 83704**
**208-378-9510**

**SUMMARY**

The Idaho Life and Health Insurance Guaranty Association Act (Chapter 43, Title 41, Idaho Code) provides a safety net for certain purchasers of insurance. Below is a brief summary of the law's coverage, exclusions and limitations. This Summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Idaho Life and Health Insurance Guaranty Association if they 1) live in this state and 2) hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

Persons holding policies or contracts are not protected by the Guaranty Association if:

- They are not residents of the state of Idaho, except under certain very specific circumstances; or
- The insurer was not authorized or licensed to do business in Idaho at the time the policy or contract was issued.

The Association also does **not** provide coverage for:

- Persons holding policies issued by a reciprocal insurer, mutual benefit association, fraternal benefit society, hospital or medical service corporation, or limited managed care plan.
- Any policies or contracts or any part of a policy or contract under which the risk is borne by the policyholder.
- Any policy of reinsurance (unless an assumption certificate was issued).
- Interest rate yields that exceed the minimum amount guaranteed by the policy or contract.
- Plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company serves as administrator).
- Any unallocated annuity contract.

**LIMITS ON AMOUNT OF COVERAGE**

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than the insurance company would owe under a policy or contract. Furthermore, the amounts the Association is authorized to pay are limited as follows:

- **Net Cash Surrender or Withdrawal Values:** Up to a total of $ 100,000 under one or more life insurance, disability insurance, or annuity policies or contracts with respect to any one life.
- **Accident and/or Health or Disability Insurance:** Up to a total of $ 300,000 of claims or benefit payments under one or more policies on any one life.
- **Life Insurance:** Up to a total death benefit of $ 300,000 under one or more policies on any one life.
- **Annuities:** Up to a total of $ 300,000 of annuity benefit payments under one or more contracts for which periodic annuity payments have begun to be paid, on any one life.

**For any one life insured, the Association will pay a maximum of $ 300,000 - no matter how many policies or contracts were issued by the insurance company, even if the policies provide different types of coverage.**

# Aetna Life Insurance Company

ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

**ILLINOIS LIFE AND**
**HEALTH INSURANCE GUARANTY ASSOCIATION**

***DISCLAIMER***

**The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.**

**You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.**

**The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:**

**Illinois Life and Health Insurance Guaranty Association**
**8420 West Bryn Mawr Avenue**
**Chicago, Illinois 60631**
**(312) 714-8050**

**Illinois Department of Insurance**
**320 West Washington Street 4th Floor**
**Springfield, Illinois 62767**
**(217) 782-4515**

**SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE**

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions; nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

a) **Coverage:**

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

1) life insurance, health insurance, and annuity contracts;
2) life, health or annuity certificates under direct group policies or contracts;
3) unallocated annuity contracts; and
4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

b) **Exclusions from Coverage:**

1) The Guaranty association does not provide coverage for:

A) any policy or portion of a policy for which the individual has assumed the risk;
B) any policy of reinsurance (unless an assumption certificate was issued);
C) interest rate guarantees which exceed certain statutory limitations;
D) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or government lottery;
E) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
F) any stop loss insurance.

2) In addition, persons are not protected by the Guaranty Association if:

A) the Illinois Director of insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
B) their policy was issued by an organization which is not a member insurer of the Association.

c) **Limits on Amount of Coverage:**

1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:

A) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or

B) with respect to any one life, regardless of the number of policies, contracts, or certificates:

i) in the case of life insurance, $ 300,000 in death benefits but not more than $ 100,000 in net cash surrender or withdrawal values;
ii) in the case of health insurance, $ 300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
iii) with respect to annuities, $ 100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $ 100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $ 5,000,000 in benefits per contract holder, regardless of the number of contracts.

However, in no extent is the Guaranty Association liable for more than $ 300,000 with respect to any one individual.

# Aetna Life Insurance Company

GENERAL PURPOSES AND
LIMITATIONS OF THE KANSAS
LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION
K.S.A. 40-3001, et. Seq.

**DISCLAIMER**

The Kansas Life and Health Insurance Guaranty Association may not provide coverage for all or a portion of this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and is dependent upon continued resident in Kansas. Therefore, you should not rely upon coverage by the Kansas Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Insurance companies and their agents are prohibited by law from using the existence of the Kansas Life and Health Insurance Guaranty Association in selling you any form of an insurance policy, or to induce you to purchase any form of an insurance policy. Either the Kansas Life and Health Insurance Guaranty Association or the Kansas Insurance Department will respond to any questions you have regarding this document.

The Kansas Life and Health Insurance Guaranty Association
2909 SW Maureen Lane
Topeka, KS 66614-5335

The Kansas Insurance Department
420 Southwest 9th Street
Topeka, KS 66612-1678

This is a summary of the basic provisions of the Kansas Life and Health Insurance Guaranty Association Act. It is only a summary, and does not provide an in depth analysis of that act. Nothing in this summary modifies the rights of persons who are protected by the act, or the rights or duties of the association.

The purpose of the Kansas Life and Health Insurance Guaranty Association Act is to protect certain individuals who purchase life insurance, annuities or health insurance in Kansas. The act provides for the establishment of a funding mechanism to pay benefits or provide insurance coverage to individuals when a life or health insurance company is unable to meet its obligations by reason of insolvency or financial impairment. However, not all individuals with a right to recover under life or health insurance policies are protected by the act. An individual is only provided protection when:

1. the individual, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, is the beneficiary, assignee or payee of a covered policy or contract holder,
2. the individual policy or contract holder is a resident of the state of Kansas,
3. the individual is not a resident of the state of Kansas, but only with respect to an annuity contract which has been awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action,
4. the individual is not a resident of the state of Kansas, but only under all of the following conditions:

    a. the impaired or insolvent insurer was a Kansas domestic insurer; and

b. the insurer never had a license to do business in the state in which the individual resides; and
c. the state in which the individual resides has an association similar to this state's; and
d. the individual is not eligible for coverage by the association of the state in which the individual resides.

Additionally, the association may not provide coverage for the entire amount the individual expects to receive from the policy. The association does not provide coverage for any portion of the policy where the individual has assumed the risk, for any policy of reinsurance, for interest rates that exceed a specified average rate, for employers' plans that are self funded, for parts of plans that provide dividends or credits in connection with the administration of the policy, for policies sold by companies not authorized to do business in Kansas, or for any unallocated annuity contract. Also, the association will not provide coverage where any guaranty protection is provided to the individual under the laws of the insolvent or impaired insurer's state of domicile.

The act also limits the amount the association is obligated to pay individuals on various policies. The association does not pay more than the amount of the contractual obligation of the insurance company. Regardless of the number of policies or contracts the association is not obligated to pay amounts over $ 300,000 in life insurance death benefits; $ 100,000 in net cash surrender and net cash withdrawal values for life insurance, $ 100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $ 100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, unless the annuity contract is awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action; or more than $ 300,000 in the aggregate for the above coverage's with respect to any one life.

# Aetna Life Insurance Company

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**DISCLAIMER**

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

| | |
|---|---|
| LLHIGA<br>P.O. Drawer 44126<br>Baton Rouge, LA 70804 | Department of Insurance<br>P.O. Box 94212<br>Baton Rouge, LA 70804-9214 |

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

1. However, persons owning such policies are not protected by this association if:

a. they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);

b. the insurer was not authorized to do business in this state;

c. their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

2. The association also does not provide coverage for:

a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

b. any policy of reinsurance (unless an assumption certificate was issued);

c. interest rate yields that exceed an average rate;

d. dividends;

e. credits given in connection with the administration of a policy by a group contract holder;

f. employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

g. unallocated annuity contracts (which give rights to group contractholders, not individuals); unless qualified under § 403(b) of the Internal Revenue Code, except that, even if qualified under § 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $ 300,000, no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $ 300,000 limit, the association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in health insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

# Aetna Life Insurance Company

## MARYLAND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND HEALTH INSURANCE GUARANTY CORPORATION SUBTITLE

Residents of this State who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this State to write these types of insurance are members of the Maryland Life and Health Insurance Guaranty Corporation. The purpose of this is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty corporation will assess its other member insurance companies for the money to pay the claims of insured persons who live in this State and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty corporation is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Maryland Life and Health Insurance Guaranty Corporation may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Maryland. You should not rely on coverage by the Maryland Life and Health Insurance Guaranty Corporation in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty corporation to induce you to purchase any kind of insurance policy.

The Maryland Life and Health Insurance
Guaranty Corporation
9199 Reistertown Road
P.O. Box 671 -- Suite 216C
Owings Mills, Maryland 21117
(410) 998-3907

The State law that provides for this safety-net is called the Life and Health Insurance Guaranty Corporation.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

Following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the law or the rights or obligations of the guaranty corporation.

## COVERAGE

Generally, individuals will be protected by the Life and Health Guaranty Corporation if they live in this State and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are not protected by this corporation if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this State;
- their policy was issued by a Health Maintenance Organization, a fraternal benefit society, a mandatory State pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessment, or by an insurance exchange.

The corporation also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance, unless assumption certificates have been issued);
- interest rate yields that exceed an average rate;
- any portion of a policy or contract to the extent that it provides dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

## LIMITS ON AMOUNT OF COVERAGE

The statute also limits the amount the corporation is obligated to pay. The corporation cannot pay more than the amount the insurance company would owe under a policy or contract. Also, with respect to any one insured life, regardless of the number of policies or contracts with the member insurer, the corporation will pay a maximum of:

- $ 300,000 in life insurance death benefits, but will not pay more than $100,000 in life insurance cash surrender values;
- $ 300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values; and
- $ 100,000 in the present value of annuity benefits, including any net cash surrender and net cash withdrawal values.

These amounts are the maximums, no matter how many policies and contracts the insured has with the member company.

# Aetna Life Insurance Company

**151 Farmington Avenue**
**Hartford, CT 06156**

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

MINNESOTA LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION
4640 West 77th Street, Suite 342
Edina, Minnesota 55435
(612) 831-1908

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $ 300,000. Subject to this $ 300,000 limit, the guaranty association will pay up to $ 300,000 in life insurance death benefits, $ 100,000 in net cash surrender and net cash withdrawal values for life insurance, $ 300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $ 100,000 in annuity net cash surrender and net cash withdrawal values, $ 300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $ 300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, [FN1] as amended through December 31, 1992, are covered up to $ 100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $ 7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $ 7,500,000, the $ 7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF

THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

# Aetna Life Insurance Company

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy. YOU MAY CONTACT EITHER THE ASSOCIATION OR THE MISSOURI DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESSES SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE.

The Missouri Life and Health Insurance Guaranty Association
520 Dix Road, Suite D
Jefferson City, MO 65109

Missouri Insurance Department
P.O. Box 690
Jefferson City, MO 65109

The state law that provides for this safety-net is called the Missouri Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when:

1. The person is eligible for protection under the laws of another state;

2. The person purchased the insurance from a company that was not authorized to do business in this state;

3. The policy is issued by an organization which is not a member insurer of the association; or

4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees). The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars ($ 300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars ($ 100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars ($ 100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars ($ 100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars ($ 300,000) for any one insured for any combination of insurance benefits.

# Aetna Life Insurance Company

SUMMARY OF MISSISSIPPI LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION ACT
AND NOTICE CONCERNING COVERAGE

LIMITATIONS AND EXCLUSIONS

Residents of this state who purchase life insurance, health insurance, or annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association") may not provide coverage for this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association when selecting an insurer.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. You may contact either the Guaranty Association or the Mississippi Insurance Department at the following addresses if you should have any questions regarding this notice.

The Mississippi Life and Health Insurance Guaranty Association
300 North Mart Plaza, Suite 2
Jackson, Mississippi 39206

Mississippi Insurance Department
1804 Walter Sillers Building
Jackson, Mississippi 39205

The state law that provides for this safety-net coverage is called the Mississippi Life and Health Insurance Guaranty Association Act (the "Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, or health insurance contract or policy, or an annuity contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a hospital or medical service organization whether profit or nonprofit, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or other person that operates on an assessment basis, an insurance exchange, or any similar entity.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy or contract of reinsurance, unless an assumption certificates were issued pursuant to the reinsurance policy or contract;
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits or payment of any fees or allowances to any person in connection with this service to or administration of the policy or contract;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under federal Pension Benefit Guaranty Corporation ("PBGC") regardless of whether the PBGC has yet become liable to make any payments with respect to the benefit plan;
- Portions of any unallocated annuity contract not issued to or in connection with a specific employee, union or association of natural persons benefit plan, or a government lottery;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association with respect to the policy or contract are preempted by State or Federal law;
- Obligations that do not arise under the express written terms of the policy or contract, including claims based on marketing materials, side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements, or claims for policy misrepresentations, or extra-contractual or penalty or consequential or incidental damages claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts, the maximum obligation of the Guaranty Association is $ 300,000 in benefits except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Guaranty Association is $ 500,000. Within these overall limits, the Guaranty Association will not pay more than $ 300,000 in life insurance death benefits, $ 100,000 in net cash surrender and net cash withdrawal values, $ 300,000 for disability insurance benefits, $ 500,000 for basic hospital, medical and surgical insurance or major medical insurance benefits, $ 100,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $ 5,000,000 limit with respect to any contract owner for unallocated annuity benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or to the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

# Aetna Life Insurance Company

**NOTICE**

The Montana Life and Health Insurance Guaranty Association may or may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and also require continued residency in Montana. You should not rely on coverage by the Montana Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

COVERAGE IS NOT PROVIDED BY THE MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION FOR YOUR POLICY OR CONTRACT OR ANY PORTION OF IT UNDER WHICH THE RISK IS BORNE BY YOU, THE POLICYHOLDER.

Insurance companies or their producers are required by law to give or send you this notice. However, insurance companies and their producers are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

This information is provided by:

Montana Life and Health Insurance Guaranty Association
P.O. Box 541
Helena, Montana 59624
1-877-678-1048

State of Montana Department of Insurance
840 Helena Avenue
Helena, Montana 59601
(406) 444-2040
1-800-332-6148

# Aetna Life Insurance Company

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholder will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

T he North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Division
Post Office Box 26387
Raleigh, North Carolina 27611

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

**COVERAGE**
Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**
However, persons owning such policies are not protected by the association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

**LIMITS ON AMOUNT OF COVERAGE**
The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for one individual, the association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. For any one group holder of an unallocated annuity contract, the association will pay a maximum of $ 5,000,000.

# Aetna Life Insurance Company

SUMMARY OF THE 1996 NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT (RSA 408-B)
AND
NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of New Hampshire who purchase life insurance, health insurance, and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

**IMPORTANT DISCLAIMER**

The New Hampshire Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Hampshire. Other conditions may preclude coverage.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to provide you with this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.**

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association
47 Hall Street, Suite 2
Concord, NH 03301
(603) 226-9114

New Hampshire Department of Insurance
56 Old Suncook Road
Concord, NH 03301
(603) 271-2261

**SUMMARY:**

The 1996 state law that provides for this safety-net coverage is called the New Hampshire Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

**COVERAGE:**
Generally, individuals will be protected by the New Hampshire Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance policy or an annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, assignees or payees of insured persons are protected as well, even if they live in another state.

Coverage provided under this Act may be different from coverage provided prior to 1996, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

**EXCLUSIONS FROM COVERAGE:**
Persons holding such policies or contracts are NOT protected by this Association if:

- they are not residents of the state of New Hampshire, except under certain very specific circumstances;
- they are eligible for protection under the laws of another state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or an entity that operates on an assessment basis, an insurance exchange, or any entity similar to any of the above.

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy holder or contract holder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with this policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire;
- any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law.

**LIMITS ON AMOUNT OF COVERAGE:**
The Act also limits the amount the Association is obligated to pay: The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one life, the Association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the Association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in health insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits.

With respect to any one contract holder of an unallocated annuity contract, not including a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue code, the Association will pay a maximum of $ 5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.

**ADDITIONAL INFORMATION:**

Policyholders should contact the New Hampshire Insurance Department with questions they may have with regard to concerns about their rights under the Act and procedures for filing a complaint to allege a violation of the Act.

Policyholders may contact the New Hampshire Insurance Department for sources of information about the financial condition of insurers.

# Aetna Life Insurance Company

NEW JERSEY LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**DISCLAIMER**

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
9th Floor
Newark, NJ 07102

State of New Jersey
Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

**COVERAGE**

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change

anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health insurance or long-term care insurance contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy was issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

**LIMITATIONS OF COVERAGE**

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $ 500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $ 100,000 in cash surrender values for annuity benefits, $ 500,000 in life insurance death benefits or $ 500,000 in present value of annuities--again no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $ 2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

# Aetna Life Insurance Company

## NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT SUMMARY DOCUMENT

Residents of Nevada who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Guaranty Association). The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association assesses its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**The Nevada Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Nevada Life and Health Insurance Guaranty Association when selecting an insurance company or when selecting an insurance policy.**

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the Insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus.

Insurance companies are required by law to deliver this notice to you. **However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association for sales, solicitation or to induce the purchase of any kind of insurance policy.**

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. **Anyone may obtain additional information or file a complaint with the Commissioner of Insurance, at the address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.**

**The Nevada Life and Health Insurance Guaranty Association**
**P.O. Box 3302**
**Reno, Nevada 89505**

**Commissioner of Insurance, State of Nevada**
**Department of Business and Industry, Division of Insurance**
**788 Fairview Drive, Suite 300**
**Carson City, Nevada 89701-5491**

**COVERAGE**

Generally, individuals will be protected by the Nevada Life and Health Insurance Guaranty Association if they live in this state and **hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract issued by a member insurer.** The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are **not** protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside the state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), a health maintenance organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $ 300,000, regardless of how many policies and contracts there were with the same company, and even if they provided different types of coverage. Within this overall $ 300,000 limit, the Association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

With respect to health insurance for any one natural person, the Association will not pay more than: 1) $ 100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash surrender or withdrawal; 2) $ 300,000 for disability insurance; or 3) $ 500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $ 100,000 in present value of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to any one life or person, in no event will the Association be obligated to cover more than: 1) an aggregate of $ 300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or 2) an aggregate

of $ 500,000 in benefits, including benefits for basic hospital, medical and surgical insurance or major medical insurance.

With respect to one owner of several nongroup policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than $ 5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

# Aetna Life Insurance Company

**OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER AND NOT COVERED FORM**

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Ohio Life and Health Insurance Guaranty Association**
**1840 Mackenzie Drive**
**Columbus, Ohio 43220**

**Ohio Department of Insurance**
**2100 Stella Court**
**Columbus, Ohio 43266-0566**

# Aetna Life Insurance Company

SUMMARY
COVERAGE, LIMITATIONS AND EXCLUSIONS UNDER
RHODE ISLAND LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
("Act")

A resident of Rhode Island who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

## IMPORTANT DISCLAIMER

RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
235 PROMENADE STREET, PROVIDENCE, RI 02908
TEL (401) 273-2921

The Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Rhode Island. You should not rely on coverage by the Association in selecting an insurance company or an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus or self funded plans.

Insurance companies or their agents are required by law to give or send you this summary. However, they are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy. Should you seek information as to the financial condition of any insurer or should you have any complaint as to an insurer's violation of the Act, you may contact the Division of Insurance at the address listed below.

RHODE ISLAND DIVISION OF INSURANCE
222 Richmond Street, Providence, RI 02903
TEL (401) 222-2223

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen. Laws §27-34.3-1. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGE: Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE: The Association does **NOT** protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administrators the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.

LIMITATIONS ON COVERAGE: The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $ 300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- $ 100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values;
- $ 300,000 for disability insurance;
- $ 500,000 for basic hospital, medical, and surgical or major medical insurance;
- $ 100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- $ 100,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $ 100,000, in the aggregate, of the present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased;

- $ 5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $ 100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $ 300,000 in the aggregate per individual except hospital insurance up to $ 500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $ 5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws §27-34.3-3.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Important Disclaimer, above.

# Aetna Life Insurance Company

**NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.**

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.**

**Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation or inducement to purchase any kind of insurance policy.**

The South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
500 East Capitol, Pierre, South Dakota 57501-5070
Tel. (605) 773-3563
www.state.sd.us/dcr/insurance

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificatieholder under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO. a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy forms, claims based on misrepresentations of policy benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer.

**LIMITS ON AMOUNT OF COVERAGE**

The Guaranty Association in no event will pay more than what the insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $ 300,000 in death benefits and not more than $ 100,000 in net cash surrender and net cash withdrawal values; (ii) for health insurance, not more than $ 500,000 for basic hospital, medical and surgical insurance, not more than $ 300,000 for disability insurance, and not more than $ 100,000 for other types of health insurance; and (iii) for annuities, not more than $ 100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $ 300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance, for which the aggregate liability of the guaranty association may not exceed $ 500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

**ADDITIONAL INFORMATION**

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Insurance Related Links" on the website of the South Dakota Division of Insurance at www.state.sd.us/dcr/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

# Aetna Life Insurance Company

## NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

**COVERAGE**

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $ 300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $ 300,000 limit, the association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in health insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits -- again, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**TENNESSEE LIFE AND HEALTH INSURANCE**
**GUARANTY ASSOCIATION**
**1200 FIRST UNION TOWER 150 4TH AVENUE**
**NORTH NASHVILLE, TENNESSEE 37219-2433**

**TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE**
**500 JAMES ROBERTSON PARKWAY**
**NASHVILLE, TENNESSEE 37243**

**NOTICE**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Guaranty Association. The purpose of

this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and is not available at all for some policies.

**COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.**

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

**TENNESSEE LIFE AND HEALTH INSURANCE**
**GUARANTY ASSOCIATION**
**1200 FIRST UNION TOWER 150 4TH AVENUE**
**NORTH NASHVILLE, TENNESSEE 37219-2433**

**TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE**
**500 JAMES ROBERTSON PARKWAY**
**NASHVILLE, TENNESSEE 37243**

# Aetna Life Insurance Company

**TEXAS LIFE, ACCIDENT, HEALTH & HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION**

The following summary information is required by law to be attached to all life and health insurance policies and annuity contracts issued in the state of Texas.

**Important Information About Coverage Under the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the *Texas Insurance Code*, Article 21.28-D.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

*Eligibility for Protection by the Association*

When an insurance company, which is a member of the Association, is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time that their insurance company is impaired
- Residents of other states, ONLY if the following conditions are met:

1. The policyholder has a policy with a company based in Texas;
2. The company has never held a license in the policyholder's state of residence;
3. The policyholder's state of residence has a similar guaranty association; and
4. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

*Limits of Protection by Association*

Accident, Accident and Health, or Health Insurance:

- Up to a total of $200,000 for one or more policies for each individual covered.

Life Insurance:

- Net cash surrender value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life.

Individual Annuities:

- Net cash surrender amount up to a total of $100,000 under one or more policies owned by one contractholder.

Group Annuities:

- Net cash surrender amount up to $100,000 in allocated benefits under one or more policies owned by one contractholder; or
- Net cash surrender amount up to $5,000,000 in unallocated benefits under one contractholder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

**When you are selecting an insurance company, you should not rely on coverage by the Association.**

Texas Life, Accident, Health
and Hospital Service Insurance
Guaranty Association
301 Congress, Suite 500
Austin, Texas 78701
800-982-6362

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439

# Aetna Life Insurance Company

## UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

### PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

### POLICIES COVERED

ULHIGA provides coverage for certain life, health and annuity insurance policies.

### EXCLUSIONS AND LIMTATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's guaranty association.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

### LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 -- whichever is lower. Other caps also apply:

- $ 200,000 in net cash surrender values.
- $ 500,000 in life insurance death benefits (including cash surrender values).
- $ 500,000 in health insurance benefits.
- $ 200,000 in annuity benefits -- if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $ 5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).

Interest rates on some policies may be adjusted downward.

### DISCLAIMER

**PLEASE READ CAREFULLY:**

**COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THS POLICY, OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

**COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

**THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

**INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

**THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance Guaranty Association
955 E. Pioneer Road
Draper, Utah 84020

Utah Insurance Department
State Office Building
Room 3110
Salt Lake City, Utah 84114

# Aetna Life Insurance Company

## THE WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

**PREFACE**

This notice briefly describes the coverage provided through the Washington Life & Disability Insurance Guaranty Association ("Association").

This Association is a nonprofit unincorporated legal entity created by the Washington Life and Disability Insurance Guaranty Association Act, Chapter 48.32A RCW ("Act"), under the laws of 1971 and 2001. Every life and disability insurance company authorized to do business in Washington is a member of the Association. A Board of Directors ("Board"), composed of representatives from member insurers, and the Insurance Commissioner, ex officio, oversee the operation of the Association.

The expenses of the Association are paid by assessments against each member insurer. Persons covered by the Act are not charged for the expenses of the Association or the protection provided under the Act.

Coverage is provided for certain life and disability insurance. However, the Association does not cover all such insurance. Coverage that is provided is subject to the limitations and exclusions provided by the Act.

The purpose of this notice is to help you understand the general nature and the conditions of the protection provided under the Act. It is only a summary, however, and if you have specific questions that are not discussed here you may contact either the Association or the Office of the Insurance Commissioner.

Washington Life and Disability Insurance Guaranty Association
P.O. Box 50303
Bellevue, WA 98015
425-562-3128

Company Supervision Division
Office of the Insurance Commissioner
P.O. Box 40259
Olympia, WA 98504-0259
360-407-0535

WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

The Act applies to life insurance policies, disability insurance policies, and annuity contracts issued by an insurance company authorized to do business in Washington. The term "disability insurance", as used in the Act, includes not only disability income insurance, but also policies commonly referred to as "health insurance". Together, all of these policies and contracts are sometimes referred to as "covered policies", a term used in this notice.

ARE THERE POLICIES OR INSURERS NOT COVERED BY THE ACT?

The Act specifically excludes certain types of policies or portions of policies, including, but not limited to: The portion of a policy not guaranteed by the insurer; the portion of a policy to the extent the interest rate or crediting rate exceeds the limits in the Act; policies of reinsurance, unless assumption certificates have been issued; policies issued in Washington by an insurer at a time when the insurer was not licensed or did not have a

certificate of authority; policies issued to a self-insured plan or program; certain unallocated employee benefit plan annuities protected by federal law; and unallocated annuity contracts not issued to or in connection with a benefit plan or a government lottery.

The Act also does not apply to policies or contracts issued by health care service contractors, health maintenance organizations, fraternal benefit societies, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or an organization that has a certificate or license limited to issuance of certain charitable gift annuities.

WHO IS PROTECTED UNDER THE ACT?

You are covered by the Act if you are an owner of or certificate holder under a policy or contract (other than an unallocated annuity contract or structured settlement annuity), and:

- You are a Washington resident; or
- You are not a Washington resident, but only if: the insurer is domiciled in Washington; there is an association similar to the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or
- You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for nonresident certificate holders under group policies).

Owners of unallocated annuity contracts are covered if the contract was issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Washington, or the contract was issued to or in connection with a government lottery and the owner is a Washington resident.

A payee under a structured settlement annuity (or beneficiary of a deceased payee) is also covered, if the payee is a Washington resident, or the payee is not a Washington resident, but the contract owner is a resident; or the insurer that issued the annuity is domiciled in Washington and coverage is not available in the state in which the payee resides.

Residency is determined at the time of entry of an order of rehabilitation, conservation or liquidation against the insurer. If you move to another state and reside there when such an order is entered, you may still have protection under the law of that state. You should contact the insurance department in your new state of residence to find out about guaranty act protection there.

HOW DOES THE ASSOCIATION PROTECT COVERED PERSONS AGAINST LOSS?

After an order of rehabilitation, conservation or liquidation is entered against a company, the Association begins its work of carrying out the purpose of the Act, which is to assure the performance of insurance obligations of that company. The Association is authorized to carry out its duties by working with insurance companies in good standing to assume or take over the covered policies. Often this is the best solution for covered persons because the insurance policy or annuity contract remains in force rather than being terminated.

The Association also has the authority to collect the funds necessary to provide protection to covered persons against losses on their covered policies.

WHERE DOES THE ASSOCIATION GET THE MONEY TO PROVIDE THIS PROTECTION?

The Association is authorized to collect money from all life and disability insurance companies doing business in Washington. The funds collected from an assessment are

used to pay claims to covered persons and/or to fund the assumption of covered policies by another insurer.

DOES THE ASSOCIATION PAY OUT THE MONEY IT COLLECTS RIGHT AWAY OR DO COVERED PERSONS HAVE TO WAIT?

The earliest that the Association can make an assessment for covered policies issued by a company is after an order of rehabilitation, conservation or liquidation has been entered against the company, and a reasonable estimate of the amount of money needed can be made. Insurance companies receiving an assessment notice must make their payments within thirty days.

Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time period of twelve to eighteen months is not unusual.

When necessary, the Association may borrow money to make payments more promptly, particularly in cases that will take an unusual amount of time to be resolved.

WHAT IS THE AMOUNT OF PROTECTION PROVIDED BY THE ACT?

The Act provides the following maximum amounts of protection:

Life Insurance Death Benefits..... $ 500,000

Disability Benefits..... $ 500,000

Present Value of Individual Annuities..... $ 500,000

Unallocated Annuity Contracts, other than certain government retirement plans (limit is per contract owner or plan sponsor)..... $ 5,000,000

Government Retirement Plans established under Internal Revenue Code sections 401, 403(b), or 457 (limit is per participant)..... $ 100,000

This protection becomes effective at the time of entry of a Court order of rehabilitation, conservation or liquidation against the insurer. Of course, if the amount owed under the contract or policy is less than the maximum benefit under the Act, the covered person will be entitled to protection only up to the actual amount owed.

Furthermore, the maximum protection available to each covered person remains the same, regardless of the number of contracts through which he or she has a claim.

IF A HUSBAND AND WIFE EACH OWN A COVERED POLICY, IS THE PROTECTION UNDER THE ACT PROVIDED TO EACH OF THEM?

Yes. As long as the residency requirements are met, both would be entitled to the protection provided by the Act, up to the maximum amount.

WHY DOESN'T MY INSURANCE COMPANY ADVERTISE THE FACT THAT ITS POLICIES AND CONTRACTS ARE PROTECTED UNDER THE ACT?

Under Washington law, insurance companies are prohibited from advertising that their policies or contracts may be covered under the Act.

You should not rely on coverage under the Act when selecting an insurance company.

WHY HASN'T MY AGENT TOLD ME ABOUT THE GUARANTY ACT?

Your insurance agent is subject to the same prohibitions as your insurance company. As a representative of the company, an agent must exercise great care when soliciting business and consequently will generally not discuss the subject of a guaranty act with clients.

WHO SHOULD I CONTACT IF I BELIEVE THERE HAS BEEN A VIOLATION OF THE ACT?

You should contact the Association if you believe your rights have been violated under the Act. If you are dissatisfied with the actions of the Association, you may also contact the Office of the Insurance Commissioner.

**CONCLUSION**

This notice has been prepared by the Washington Life and Disability Insurance Guaranty Association. Its purpose is to inform the public in a general way of the protections that are available in this state on insurance policies and annuity contracts issued by companies authorized to do business in Washington. The Association does not, by the notice, endorse any company or its products, but rather seeks to address some of the concerns that you may have regarding the security of insurance policies and annuity contracts.

For more information or answers to specific questions you may contact the Washington Life and Disability Insurance Guaranty Association or the Washington Department of Insurance, whose address and telephone number are shown in the Preface.

# Aetna Life Insurance Company

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE WEST VIRIGNIA
LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
2019 Washington Street, East
P.O. Box 50540
Charleston, West Virginia 25305-0540
(304) 558-3386
Toll Free 1-800-642-9004
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law;

nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group life, health or annuity insurance contract, issued by a member insurer. Member insurer also includes non-profit service corporations and health care corporations. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**
However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy was issued at a time when the insurer was not licensed or authorized to do business in the state;
- their policy was issued by an HMO, a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an entity similar to the above.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual or contract holder has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:

  i. multiple employer welfare arrangement;
  ii. minimum premium group insurance plan;
  iii. stop loss group insurance plan; or
  iv. administrative services only contract.
- any unallocated annuity contract issued to an employee benefit plan protected under the federal pension guaranty corporation;
- any portion of any unallocated contract which is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery.

**LIMITS ON AMOUNT OF COVERAGE**
The act also limits the amount the Guaranty Association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in health insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits --again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $ 150,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $ 300,000 in the aggregate per individual; for covered unallocated annuities that fund other plans, a special limit of $ 1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

Policyholder No. 101979

# Group Accident and Health Insurance Policy

a contract between

**Aetna Life Insurance Company**
(A Stock Company herein called Aetna)

and

**Parsons Brinckerhoff Group Administration Inc.**
(Policyholder)

| | |
|---|---|
| **Policy Number:** | GP-101979 |
| **Date of issue:** | March 29, 2005 |
| **To take effect:** | January 1, 2005 |
| **Policy delivered in:** | New York |

This policy will be construed in line with the law of the jurisdiction in which it is delivered.

Based on timely premium payments by the Policyholder, Aetna agrees with the Policyholder, to pay benefits in line with the policy terms.

The duties and the rights of all persons will be based solely on policy terms. This policy is non-participating.

Signed at Aetna's Home Office in Hartford, Connecticut on the date of issue.

Ronald A Williams

President

Registrar

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# Index

**Policy Contents**

**Part I**

- **Eligible Classes**
- **Changes**
- **Special Provisions**

**Part II**

**Policyholder and Insurance Company Matters**

# Policy Contents

This policy consists of:

The Face Page, Index, this Policy Contents page, and all the provisions of Parts I and II; and

The provisions found in the Certificate(s) listed in this section.

The words "you" or "your" in any Certificate included in this policy, will refer to a covered Employee.

The Certificate(s) included in this policy are as follows:

A "Certificate" consists of a Certificate Base document ("Cert. Base") and any Summary of Coverage ("SOC") or Certificate Rider ("Rider") which may be issued to support or amend the Cert. Base.

| Identification | Issue Date | Effective Date | Comments |
|---|---|---|---|
| Cert Base 1 | March 29, 2005 | January 1, 2005 | LTD Class 1&2 |
| SOC 1A | March 29, 2005 | January 1, 2005 | Plan B (Base) |
| Cert Base 2 | March 29, 2005 | January 1, 2005 | TDI |
| SOC 2A | March 29, 2005 | January 1, 2005 | All Classes |
| Cert Base 3 | March 29, 2005 | January 1, 2005 | LTD Class 4 |
| SOC 3A | March 29, 2004 | January 1, 2005 | Plan I (Base) |
| Rider 1 | March 29, 2005 | January 1, 2005 | All Plans |

# Part I

## Eligible Classes

All classes of employees of a Member Employer are eligible except those who are:

Part-time;

Temporary;

Substitute; or

In a class for which a Certificate is not in this policy.

An employee is eligible only for the coverages shown in the Certificate which applies to his class.

If a Member Employer is a partnership or proprietorship, each of its natural-person partners, or the proprietor, will be deemed to be an employee. This applies only if the person is working on a mostly full-time basis for the Employer.

# Change In Amounts

**Employee Coverage (Contributory) (This section does not apply to Long Term Disability Coverage or Managed Disability Coverage)**

## Earnings or Status Change

If, at any time, the employee's rate of earnings or status changes so as to warrant an amount of contributory coverage other than that for which the employee is then covered, the amount of his or her coverage will be changed as follows:

A reduction will be effective:

On the date the employee requests it under Life Insurance and Accidental Death and Personal Loss Coverage.

On the date of the earnings or status change under all other coverages.

An increase will be effective on the date of the earnings or status change. For any coverage other than Health Expense Coverage, the Active Work Rule must be met. The employee may refuse an increase in Life Insurance or Accidental Death and Personal Loss Coverage. This must be done within 31 days of the date it would have taken effect. If refused, no other increase because of the earnings or status change will be made until the date Aetna gives written consent.

## Schedule or Benefit Level Change

If, at any time, any schedule or the level of any benefit is changed so as to warrant an amount of contributory coverage other than that for which the employee is then covered, the amount of coverage will be changed to the new amount. For any coverage other than Health Coverage, an increase will be subject to the Active Work Rule.

The employee may refuse an increase in Life Insurance and Accidental Death and Personal Loss Coverage. This must be done within 31 days of the date it would have taken effect. If the employee later elects the increase, it will be made on the date Aetna gives written consent.

# Change In Amounts (Continued)

**Employee Coverage (Contributory) (Continued)**

### All Changes

A retroactive change in an employee's rate of earnings or status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in earnings or status is made.

This section will not apply to reductions due to reaching a stated age or due to retirement.

**Employee Coverage (Non-Contributory) (This section does not apply to Long Term Disability Coverage or Managed Disability Coverage)**

### Earnings, Status, Schedule, or Benefit Level Change

If, for any reason and at any time, the employee's rate of earnings, or the employee's status, or any schedule, or the level of any benefit is changed so as to warrant an amount of non-contributory coverage other than that for which the employee is then covered, the amount of his or her coverage will be changed to the new amount. For any coverage other than Health Expense Coverage, an increase will be subject to the Active Work Rule.

A retroactive change in an employee's rate of earnings or status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in earnings or status is made.

This section will not apply to any reductions due to reaching a stated age or due to retirement.

# Other Changes

**Employee Coverage**

## Addition or Deletion of a Benefit

Except as set forth in the next paragraph, if any benefit becomes applicable to an employee who is already covered under the policy, that employee will be eligible for that benefit right away. Coverage will be effective in line with the Eligibility provisions as described elsewhere in this policy. For any coverage other than Health Expense Coverage, this includes the Active Work Rule.

If any benefit no longer applies to an employee, coverage for that benefit will stop right away for that employee.

## Change in Eligibility Date

An increase in any required period of service will apply only to an employee who enters service on or after the effective date of the increase. A decrease in any required period of service will permit an employee to become eligible on the effective date of the decrease if he or she then has worked the new period of service. Otherwise he or she is eligible on the date he or she completes it.

## Change in Age Reduction Rule

If an Age Reduction Rule is changed and an employee is eligible for an increase in coverage due to such change, such increase shall be effective only if Aetna gives its written consent.

# Special Provisions

**Active Work Rule**

This Active Work Rule does not apply to any Health Expense Coverage.

If the employee is ill or injured and away from work on the date any of his or her Employee Coverage (or any increase in such coverage) would become effective, the effective date of coverage (or increase) will be held up until the date he or she goes back to work for one full day.

# Special Provisions (Continued)

## Other Long Term Disability Insurance

If there is other group long term disability insurance:

under which benefits are payable for the same period of disability; and

which contains the same or similar provisions for reduction in benefits payable because of other income benefits;

the long term disability part of this contract will be liable only for a pro rata share of the total benefits payable.

"Pro rata share" means the result of the following:

the amount payable under this contract in the absence of other group long term disability insurance benefits and before any reduction in benefits payable due to other income benefits; divided by:

the total amount payable under all group long term disability insurance plans before any reduction in benefits payable due to other income benefits; times

the benefit payable under this contract after reduction by all other income benefits except any amount payable under another group long term disability insurance plan.

# Policyholder and Insurance Company Matters (Continued)

## Duties of the Policyholder

The Policyholder and each Member Employer must give Aetna such information as Aetna may reasonably require to administer this policy and must agree to:

Maintain a reasonably complete record of such information in electronic or hard copy format, including but not limited to:

evidence of eligibility;

changes to such elections; and

terminations;

for at least seven years or until the final rights and duties under this policy have been resolved; and to make such information available to Aetna upon request.

Obtain from:

the Policyholder; and

each Member Employer.

a "Disclosure of Healthcare Information" authorization in the form currently being used by Aetna in the enrollment process; or such other form as Aetna may reasonably approve.

The information shall be provided when requested:

on Aetna forms; or

such other forms as Aetna may approve.

All data which may have a bearing on insurance or premiums will be open for Aetna to inspect while this policy is in force.

The Policyholder must notify employees of the termination of the policy in compliance with all applicable laws. However, Aetna reserves the right to notify employees of termination of the policy for any reason, including non-payment of premium. The Policyholder shall provide written notice to employees of their rights upon termination of coverage.

The Policyholder must:

notify all eligible employees of their right to continue coverage under COBRA and any applicable state law; and

provide notification to each employee within 15 days after termination of coverage, of their conversion right, including:

a description of plans available;

premium rates;

and application forms.

# Policyholder and Insurance Company Matters (Continued)

## Non-Discrimination

In the management of this policy, the Policyholder and the Member Employers:

will make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in the coverages provided by the policy based on health status or risk.

will act so as not to discriminate unfairly between persons in like situations at the time of the action.

Aetna can rely on such action. It will not have to probe into the details.

## Certificates

Aetna will provide the Policyholder with either a supply of paper copies or electronic certificates. The Policyholder shall distribute or otherwise make the certificates available to each insured employee. The insurance in force will be set forth. Statements as to whom benefits are payable will appear. Any applicable Conversion Privilege will also be described.

## Policy Changes

This policy may be amended by Aetna:

with 30 days written notice to the Policyholder; or

by written agreement between Aetna and the Policyholder.

The consent of any employee or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the policy terms or make any agreement binding Aetna. The Policyholder will not have to give written agreement of a change in the policy if:

- The Policyholder has asked for the change and Aetna has agreed to it.
- The change is needed to correct an error in the policy, including any certificate issued to anyone.
- The change is needed so that the policy will conform to any law, regulation or ruling of:

  a jurisdiction that affects a person covered under this policy; or

  the federal government.
- The change has been initiated by Aetna and is not resulting in either:

  a reduction or elimination in benefits or coverage; or

  an increase in premium.

# Policyholder and Insurance Company Matters (Continued)

**Policy Changes (Continued)**

The Policyholder will have to give written agreement of a change in the policy:

that reduces or eliminates benefits or coverage; or

that increases benefits or coverage with a concurrent increase in premium during the policy term, except if the increased benefits or coverage is required by law.

Payment of the applicable premium after notice of the proposed changes will be deemed to constitute the Policyholder's written agreement of those changes on behalf of all persons covered under this policy.

This policy shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. This policy may also be amended by Aetna:

with 30 days written notice to the Policyholder; or

by written agreement between Aetna and the Policyholder.

The consent of any employee or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the policy terms or make any agreement binding Aetna.

# Policyholder and Insurance Company Matters (Continued)

## Contract

This policy and application of the Policyholder are the entire contract. A copy of the application is attached. All statements made by the Policyholder or an employee shall be deemed representations and not warranties. No written statement made by an employee shall be used by Aetna in a contest unless:

a copy of the statement is; or

has been furnished to:

the employee; or

his beneficiary; or

the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of Aetna's right to implement; or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

## Accident and Health Coverage Statements

Except as to a fraudulent misstatement or issues concerning premiums due:

No statement made by the Policyholder or an employee shall be the basis for:

voiding coverage; or

denying coverage; or

be used in defense of a claim;

unless it is in writing.

No statement made by the Policyholder shall be used to void this policy after it has been in force for 2 years.

No statement made by an eligible employee shall be used in defense to a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

# Policyholder and Insurance Company Matters (Continued)

**Premium Rates (Continued)**

## Other Accident and Health Benefits

The premium rates for accident and health coverage are as follows. The premium rates are for a period of one month.

The current premium rates for all of the Accident and Health Coverages provided under this policy are on record with both Aetna and the Policyholder.

# Policyholder and Insurance Company Matters (Continued)

**Premium Rates (Continued)**

## Other Accident and Health Benefits (Continued)

Each premium due will be figured by obtaining the product of:

One hundredth of the amount of monthly benefit in force; and

The average rate per $100 of monthly benefit as determined below.

On the date that the Long Term Disability Benefits section takes effect, the average rate per $100 of monthly benefit will be figured by dividing the first item below by the second item below:

The sum of the individual premiums for the employees then insured, according to the table of monthly rates per $100 of monthly benefit. This is based on their ages (nearest birthday) and respective amounts of monthly benefit.

One hundredth of the approximate total amount of monthly benefits in force.

# Policyholder and Insurance Company Matters (Continued)

**Fees**

In addition to the premium, Aetna may charge:

A reinstatement fee if any or all coverage is terminated and later reinstated under this policy.

# Policyholder and Insurance Company Matters (Continued)

**Premiums Due - Experience Rating**

The premium due under this policy on any premium due date will be the sum of the premium charges for the coverages then provided under this policy.

If premiums are payable monthly, any insurance becoming effective will be charged for from the first day of the policy month on or right after the date the insurance takes effect. Premium charges for insurance which ceases will cease as of the first day of the policy month on; or right after the date the insurance terminates. If premiums are payable less often than monthly, premium charges or credits for a fraction of a premium-paying period will be made on a pro rata basis for the number of policy months between:

the date premium charges start or cease; and

the end of the premium-paying period.

If this policy is changed to provide more coverage to take effect on a date other than the first day of a premium-paying period, a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium-paying period.

The premium charges will be figured at the premium rates shown before. Aetna may change them due to:

Experience; or

a change in factors bearing on the risk assumed.

Each change shall be made by written notice to the Policyholder by Aetna.

No experience reduction or increase in premium rates shall become effective less than 12 months after the effective date of the group policy unless there is:

a significant change in factors bearing a material impact on the risk assumed by Aetna; or

changes in applicable state or federal:

law;

policy;

regulation; or

a judicial decision;

# Policyholder and Insurance Company Matters (Continued)

**Premiums Due - Experience Rating (Continued)**

having a material impact on the cost of providing the coverages then provided under this group policy. As used here, "group policy" shall be deemed to include any group policy previously issued by Aetna that has been replaced in whole or in part by this policy.

The Long Term and Managed Disability Coverage sections of this policy set forth the way in which the premium rates for such coverages will be figured. The premium charges for any other coverage under this policy may be refigured, as of a premium due date, only:

By reason of a change in factors bearing on the risk assumed. This must be requested by Aetna.

Once during any continuous 12 month period. The Policyholder must request this. 60 days advance notice has to be given to Aetna.

They will be refigured using:

The ages of the employees;

The amounts of insurance in force;

The premium rates; and

Any other pertinent factors.

All facts will be taken into account as of the date of the refiguring.

# Policyholder and Insurance Company Matters (Continued)

**Premiums Due - Experience Rating (Continued)**

At the end of a policy year, Aetna may declare an experience credit. The amount of each credit Aetna declares will be returned to the Policyholder. Upon request by the Policyholder, part or all of it will be applied against the payment of premiums or in any other manner as may be agreed to by the Policyholder and Aetna.

If the sum of employee contributions which have been made for group insurance exceeds the sum of premiums which have been paid for group insurance (after giving effect to any experience credits), the excess will be applied by the Policyholder for the sole benefit of employees. Aetna will not have to see to the use of such excess.

Instead of figuring premiums as described above, premiums may be figured in any way approved by Aetna that comes up with about the same amount of premiums.

Aetna will not have to refund any premium for a period prior to:

The first day of the policy year in which Aetna receives proof that the refund should be made; or

The date 3 months before Aetna receives proof, if this produces a larger refund.

This applies even if the premium was paid in error.

**Premium and Fees Due**

## Payment of Premiums and Fees

The Policyholder will pay premiums and fees in advance. They may be paid at Aetna's Home Office or to its authorized agent.

A premium is due to be paid on the first day of each policy month.

The Policyholder may change the number of premium payments as of a premium due date. This needs Aetna's written consent.

Aetna may accept a partial payment of premium without waiving its right to collect the entire amount due.

If the premiums and any fees are not paid by the Premium Due Date and before the end of the Grace Period, this policy will automatically terminate when the Grace Period ends. Aetna will require the Policyholder to pay interest on the total premium amount and any fees overdue after the Premium Due Date including the premiums due for the Grace Period. The interest rate will be 1 1/2% per month for each:

# Policyholder and Insurance Company Matters (Continued)

**Premium and Fees Due (Continued)**

## Payment of Premiums and Fees (Continued)

month; or

partial month;

the balance remains unpaid. Aetna may recover from the Policyholder:

costs of collecting any unpaid premiums or fees; including reasonable attorney's fees; and

costs of suit.

As to any Long Term Disability Benefits Coverage and Managed Disability Benefits Coverage under this policy for an employee, premium payments shall not be required on any premium due date during a period for which the employee is entitled to receive a benefit under Long Term Disability Benefits Coverage or a Monthly Benefit under Managed Disability Benefits Coverage.

**Retroactive Adjustments**

Aetna may, at its discretion, make retroactive adjustments to the Policyholder's billings for the termination of employees not posted to previous billings. However, the Policyholder may only receive a maximum of 1 month's credit for employee terminations that occurred more than 30 days before the date the Policyholder notified Aetna of the termination. Aetna may reduce any such credits by the amount of any payments Aetna may have made on behalf of such employees before Aetna was informed their coverage had been terminated. Retroactive additions will be made at Aetna's discretion based upon eligibility guidelines stated in the certificate, and are subject to the payment of all applicable premiums.

**Grace Period**

A grace period of 31 days after the due date will be allowed the Policyholder for the payment of each premium and fee. If premiums and fees are not paid by the end of the Grace Period, the policy will automatically terminate at the end of the Grace Period.

# Policyholder and Insurance Company Matters (Continued)

**Discontinuance of Policy**

The Policyholder may terminate this policy as to any or all coverage of all or any class of employees of any one or more Member Employers. A Member Employer may terminate this policy as to any or all coverage of all or any class of its employees. Aetna must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to Aetna as to the coverage.

In the event that any premium for any coverage except Life Insurance for all or any class of employees of a Member Employer located in Louisiana is unpaid on the last day of the grace period allowed for the payment of that premium, all coverage under this policy shall terminate at the end of that day as to such employees. This shall be deemed a unilateral termination of coverage by the Member Employer.

Aetna has the right to terminate this policy:

as to Life Insurance, as to all or any class of employees of a Member Employer.

as to any other coverage, as to all or any class of employees of a Member Employer, other than one located in Louisiana;

at any time after the end of the grace period if the premium for the employees' coverage has not been paid. Written notice of the termination date must be given by Aetna. This right is subject to the terms of any laws or regulations.

Aetna may also terminate this policy as follows:

as to Life Insurance, in its entirety or as to all or any class of employees of a Member Employer.

as to any other coverage:

in its entirety if there is not a class or classes of employees of a Member Employer located in Louisiana;

as to any or all coverage of all or any class of employees of a Member Employer, other than one located in Louisiana.

Aetna will give the Policyholder advance written notice of when it will terminate. The date will not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Aetna.

If:

this policy terminates as to any of the employees of a Member Employer; and

premiums have not been paid for the period this policy was in force for those employees;

then the Policyholder and the Member Employer shall be jointly and severally liable to Aetna for the unpaid premiums.

# Policyholder and Insurance Company Matters (Continued)

**Discontinuance of Policy**

The Policyholder may terminate this policy as to any or all coverage of all or any class of employees of any one or more Member Employers. A Member Employer may terminate this policy as to any or all coverage of all or any class of its employees. Aetna must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to Aetna as to the coverage.

Aetna may terminate this policy as to any or all coverage, other than Health Expense Coverage, which includes:

Comprehensive Medical Expense Coverage;

Major Medical Expense Coverage;

Prescription Drug Expense Coverage; and

Hospital Expense Benefit;

but does not include:

Comprehensive Dental Expense Coverage; and

Comprehensive Vision Expense Coverage;

of all or any class of employees or dependents of any one or more Member Employers by giving written notice of when it will terminate. The date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Aetna.

Comprehensive Medical Expense Coverage; Major Medical; Prescription Drug Expense Coverage; Hospital Expense Benefit may be terminated by Aetna as follows:

When the premium for the employees' coverage has not been paid. This right to terminate shall be in accordance with the Grace Period and Payment of Premiums and Fees provisions and is subject to the terms of any laws or regulations.

When the Policyholder ceases to meet the requirements for a group as defined under applicable state law or regulation.

When the Policyholder fails to meet Aetna's contribution or participation requirements. Aetna may request:

certification of the Policyholder's compliance with Aetna's participation and contribution requirements; and

certification of group status.

prior to renewal. Aetna may exercise its right to non-renew if such certification is not provided.

# Policyholder and Insurance Company Matters (Continued)

**Discontinuance of Policy (Continued)**

When the Policyholder fails, without good cause, to perform in good faith its obligations under this policy including an act or practice that constitutes fraud or intentional misrepresentation of a material fact relevant to the coverage provided under this policy.

In accordance with any applicable state or federal law, rule or regulation.

When Aetna decides to discontinue offering:

a particular type of group health expense coverage; or

all its group health expense coverage in the state the policy is issued; provided all group health expense coverages issued or delivered for issuance in such state are discontinued and not renewed.

Except if Aetna discontinues offering a type of group health expense coverage, Aetna will give the Policyholder advance written notice of when it will terminate the policy. The date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Aetna.

If Aetna discontinues offering a particular type of group health expense coverage, it shall:

provide written notice to each affected employer, (and all covered employees and dependents), of the discontinuance within 90 days before such plans discontinue;

offer each affected employer the option, on a guaranteed issue basis; to purchase any other group health benefit plan currently being offered in that market; and

act uniformly without regard to the claims experience of the affected employers; or any health status-related factor relating to any covered employee or dependent who may become eligible for coverage.

If Aetna discontinues offering all its group health expense coverages, it shall provide written notice to each affected employer, (and all covered employees and dependents), of the discontinuance at least 180 days before such discontinuance.

If:

This policy terminates as to any of the employees of a Member Employer; and

Premiums and fees have not been paid for the period this policy; or any coverage included was in force for those employees;

then the Policyholder and the Employer shall be jointly and severally liable to Aetna for the unpaid premiums and fees, including those due for the grace period. Employees shall also remain liable for employee cost sharing and other required contributions to coverage for any period of time the policy is in force during the Grace Period.

# Policyholder and Insurance Company Matters (Continued)

**Discontinuance of Policy (Continued)**

Aetna may request from the Policyholder, a written indication of their intention to renew or non-renew a policy at any time during the final three months of any policy year. If the Policyholder fails to reply to such request:

within two weeks of their receipt of the request; or

15 days prior to the renewal date;

whichever is later; then upon Aetna's written notice to the Policyholder, all or a part of the policy shall be deemed to terminate automatically as of the end of the policy year. Similarly, upon Aetna's written confirmation to the Policyholder, Aetna may accept an oral indication by:

the Policyholder; or

its agent or broker;

of intent to non-renew as the Policyholder's notice of termination of all or a part of the policy effective as of the end of the policy year.

Aetna may charge the Policyholder a reinstatement fee if any or all coverage is terminated; and later reinstated under this policy.

If this policy includes health expense coverage and the policy discontinues, the Policyholder will promptly mail to each employee insured under this policy at the time of such discontinuance, a legible, true copy of any notice of policy discontinuance which may be received from Aetna and will promptly provide Aetna proof of such mailing and the date of the mailing.

# Policyholder and Insurance Company Matters (Continued)

**ERISA Matters**

Under Section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), Aetna is a fiduciary. It has complete authority to review all denied claims for benefits under this policy. In exercising such fiduciary responsibility, Aetna shall have discretionary authority to:

determine whether and to what extent employees and beneficiaries are entitled to benefits; and

construe any disputed or doubtful terms of this policy.

Aetna shall be deemed to have properly exercised such authority. It must not abuse its discretion by acting arbitrarily and capriciously. Aetna has the right to adopt reasonable:

policies;

procedures;

rules, and

interpretations;

of this policy to promote orderly and efficient administration.

The Policyholder shall be responsible for making reports and disclosures required by ERISA, including:

the creation;

the distribution; and

the final content of:

summary plan descriptions;

summary of material modifications; and

summary annual reports.

Policyholder No. 101979

# Rider

Attached to and made a part of Group Policy No. GP-101979

a contract between

## Aetna Life Insurance Company

and the Policyholder

## Parsons Brinckerhoff Group Administration Inc.

It is understood and agreed that the policy is changed by the addition or deletion of the pages listed below.

| Page Numbers Of Pages Added | Page Numbers Of Pages Deleted |
|---|---|
| Page 9010 01 01 05 | Page 9010 |

Nothing contained in this rider shall be held to alter or affect any of the terms of the policy other than as herein specifically stated.

In Witness Whereof, the Aetna Life Insurance Company has signed this rider at Hartford, Connecticut, to become effective January 1, 2005.

Signed by the Insurance Company, June 5, 2006.

Ronald M Williams

President

# Policy Contents

This policy consists of:

The Face Page, Index, this Policy Contents page, and all the provisions of Parts I and II; and

The provisions found in the Certificate(s) listed in this section.

The words "you" or "your" in any Certificate included in this policy, will refer to a covered Employee.

The Certificate(s) included in this policy are as follows:

A "Certificate" consists of a Certificate Base document ("Cert. Base") and any Summary of Coverage ("SOC") or Certificate Rider ("Rider") which may be issued to support or amend the Cert. Base.

| Identification | Issue Date | Effective Date | Comments |
|---|---|---|---|
| Cert Base 1 | June 5, 2006 | January 1, 2005 | LTD Class 1&2 |
| SOC 1A | March 29, 2005 | January 1, 2005 | Plan B (Base) |
| Cert Base 2 | March 29, 2005 | January 1, 2005 | TDI |
| SOC 2A | March 29, 2005 | January 1, 2005 | All Classes |
| Cert Base 3 | June 5, 2006 | January 1, 2005 | LTD Class 4 |
| SOC 3A | March 29, 2004 | January 1, 2005 | Plan I (Base) |
| Rider 1 | March 29, 2005 | January 1, 2005 | All Plans |

# Aetna Life Insurance Company

Hartford, Connecticut 06156

**Rider**

**Policyholder:** Parsons Brinckerhoff Group Administration Inc.

**Group Policy No.:** GP-101979

**Effective Date:** January 1, 2005

Your Certificate provides that coverage will take effect for you only if you are not ill or injured and away from work.

If you were covered on the day before this Amendment took effect for Temporary Disability Income benefits under a prior group plan provided by your Employer, coverage under this Plan may take effect for you before you return to active work.

A benefit will not be payable under this Plan as to any period of disability covered under the prior plan.

Contact your Employer for complete details.

Ronald A. Williams
President

Rider: 1
Issue Date: March 29, 2005